REFUSAL OF RECOMMENDED MEDICAL OR SURGICAL TREATMENT

**Patient Name:**

1. **Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_provided me with the following information**
2. I have the following condition(s):
3. The doctor is recommending the following treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. The recommended treatment involves: \_\_\_\_\_\_
5. The purpose of the recommended treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_
6. I need to get the recommended treatment within the following time period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. The possible alternative(s) to the recommended treatment for which I refuse consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. The consequences of not proceeding with the recommended treatment or the above described alternative(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. **I understand that if I do not consent to the recommended treatment, I may endanger my vision, life, or health; I nonetheless refuse to consent to it.**
10. **My reason for refusing this treatment is:**

**X**

Patient (or person authorized to sign for patient) Date