**PLACE LETTERHEAD HERE AND REMOVE NOTE.**

**CHANGE FONT SIZE FOR LARGE PRINT**

NOTE: THIS FORM IS INTENDED AS A SAMPLE FORM. IT CONTAINS THE INFORMATION OMIC RECOMMENDS YOU AS THE SURGEON PERSONALLY DISCUSS WITH THE PATIENT. PLEASE REVIEW IT AND MODIFY TO FIT YOUR ACTUAL PRACTICE. GIVE THE PATIENT A COPY AND SEND THIS FORM TO THE HOSPITAL OR SURGERY CENTER AS VERIFICATION THAT YOU HAVE OBTAINED INFORMED CONSENT.

Version 3/1/2005

REFUSAL OF RECOMMENDED MEDICAL OR SURGICAL PROCEDURE/INTERVENTION

**Patient Name:**

1. **The following has been explained to me by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Physician)**
2. That I have the following condition(s):
3. That the following procedure/intervention has been recommended:
4. The nature of the recommended treatment:
5. The purpose of and need for the recommended treatment:
6. The possible alternative(s) to the recommended procedure or intervention for which I refuse consent:
7. The nature and likelihood of the consequences of not proceeding with the recommended procedure/intervention or the above described alternative(s):
8. **I understand that my failure to accept the recommended procedure/intervention may endanger my life or health; I nonetheless refuse to consent to it.**
9. **My reason for refusal is: \_\_\_\_\_**

**X**

Patient (or person authorized to sign for patient) Date

**X**

Witness Date