SAMPLE REFUSAL OF TREATMENT

I, _____, refuse to consent to the following treatment/procedure/ diagnostic test/medication/referral as recommended by my physician, _____ M.D./D.O.:

_____
_____
_____
_____

Dr. _____ has explained the recommended treatment, the benefits and risks involved, the possible alternatives to the treatment, and the consequences of my refusal to my health and well-being, and I understand all of this information.

Dr. _____ has given me the opportunity to ask questions, and the doctor has answered my questions about the proposed treatment.

I understand that my refusal is against the medical advice of my doctor.

_____ _____
(Patient's Signature) (Date)

_____ _____
(Physician's Signature) (Date)

_____ _____
(Witness Signature) (Date)

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If you would like to discuss a particular situation, please contact our risk management division at 1-888-336-2642 or riskmanagement@psicinsurance.com.