



# Refusal of treatment form

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

**(Health professional) \_\_\_\_\_ has recommended that I undergo the following test/treatment/procedure:**

I acknowledge the following (please tick all that apply):

- My medical condition has been explained to me by a health professional and/or my key worker
- The reason for the recommended test/treatment/procedure have been explained to me
- The nature of the recommended test/treatment procedure has been explained to me
- The risks and benefits of the recommended test/treatment/procedure have been explained to me
- All my questions about the recommended tests/treatment/procedure have been answered
- I have been advised by paramedics to attend hospital

The risks of refusing the recommended test/treatment/procedure/hospital attendance have been explained to me. They include but are not limited to:

**Potential delay in diagnosis and treatment of health conditions.**

I also understand there could be risks of refusing the recommended test/treatment/procedure/hospital attendance that are not known yet. Although my refusal to follow \_\_\_\_\_ (insert name of health professional here) advice and undergo the recommended test/treatment/procedure/hospital attendance could seriously impair my health or even result in death. I choose to refuse the recommended test/procedure/treatment and accept the risks and consequences of my decision. I understand that I could change this decision at any time by contacting \_\_\_\_\_ and taking action to cancel this refusal.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient name (printed): \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health professional signature (if present) \_\_\_\_\_

If you have any questions/ suggestions please contact [Westminsterhhcp@groundswell.org.uk](mailto:Westminsterhhcp@groundswell.org.uk).