TREATMENT / EXAMINATION REFUSAL DOCUMENT

Name, Sirname:
Gender:
Birth Date:

Protocol Number:
Date:
Room Number:

Date: Time :
Patient evaluation was completed / not completed in the time and date above. Possible diagnosis are:

Patient's issue requires the following attempt / examination / treatment below:

If the patient does not accept inspection / intervention / examination / treatment for specified medical condition; following results that may arise were described in details.

Doctor in charge:
Name, Sirname: Signature: Stamp:

I received detailed information from my doctor consciously on the need for implementation of examination and treatment about what is my illness and which examination I need. I learned the dangers which could threaten my health if I do not accept these tests and treatments,

Despite all this informations, I am……., I refuse the inspection / examination / treatment and I assume the responsibilities that will occur.
Patient's or patient's guardian's name, sirname (with your own handwriting):

Patient's or patient's guardians's signature:

Witness (if there is no witness, hospital authority) name sirname:

Signature of witness:

Date: Time:

Patient's guardian or withness
Phone:
Mobile Phone: