REFUSAL OF CARE FORM

newage MEDICAL CENTER

Patient: _____ *Age:* _____

Medical condition at issue: _____

Person being advised (if other than patient): _____

Physician advising: DAVID MORENO

My physician, named above, has advised that I, or an individual for whom I am a legal guardian, undergo the following test(s), treatment(s), or procedure(s):

_____

_____

_____

_____

_____

_____

_____

My physician has explained the above test(s), treatment(s), or procedure(s) to me. In doing so, my physician has explained to me the risks and benefits of his/ her recommendation; the alternatives, if any, to this recommendation; and the risks and consequences of not receiving the recommended test(s), treatment(s), or procedure(s). Specifically, my physician has advised me of the following risks in refusing the above recommended medical care:

_____

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_____

I have had the opportunity to ask questions about the proposed recommendation and the risks associated with my refusal of care, and my physician has answered any questions I have asked to my satisfaction.

Notwithstanding the recommendation of my physician and with the knowledge I have regarding this recommendation, I have decided ***NOT*** *to accept/permit the test(s), treatment(s), or procedure(s) listed above. I understand that my refusal of this recommended medical care may seriously affect my health or the health of the person under my guardianship.*

_____ _____/_____/_____ _____

Patient/Guardian *Date* *Time*

I have recommended the above medical care for this patient. To the best of my knowledge, the patient or patient's guardian understands the risk associated with the refusal of the above care, including the specific risks listed above.

_____ _____/_____/_____ _____

Physician *Date* *Time*

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INITIALS _____