McLaren Medical Group

REFUSAL TO CONSENT TO MEDICAL TREATMENT/TRANSPORT

This is to certify that I, _____, a rational and competent individual, a patient at _____
Name of Patient Name of Facility

on _____, am refusing one of the below categories against the advice of the physician:
Date of Service

1. Tests: _____
   _____
2. Procedures: _____
   _____
3. Treatments: _____
   _____
4. Left against _____
   Medical advice: _____

I acknowledge that I have been informed of the risk involved as a result of failure to consent to the tests, procedures, treatments or leaving against medical advice, and hereby release the physician and the care center from all responsibility and liability for any ill effects that may result from this refusal. I understand that this refusal could include adverse effects arising because my physician will be unable to reach a timely, correct, or accurate diagnosis of my condition, and thereby resulting in my physician's inability to promptly or correctly render treatment appropriate to my condition.

5. Refusal to be _____
   Transported: _____

I acknowledge that I have been informed of the risk involved in refusing to be transported by ambulance which may include advanced cardiac life support, intravenous support and paramedic treatment. I hereby release the ambulance company, physician and this medical care facility from all responsibility for any ill effects which may result in my decision.

_____ _____ _____
(Signature of Patient) (Time) (Date)

_____ _____
(Signature of Physician) (Signature of Witness)

If patient is unable to sign due to a question of competence or is a minor, complete the following: (If the patient is a minor or the patient is legally incompetent, please obtain the signature of the legal guardian, patient advocate or closest available relative.)

Patient is unable to sign because _____
_____
_____

_____ _____
(Signature of Witness) (Signature of Parent / Legal Guardian / Patient Advocate)

Patient Name:

Date of Birth: