

**McLaren Print System Order**

**Order No: 49645 Reprint Previous Order No: 5717**  
**Order Date: 2019-10-21**  
**User: Shannon Pierce**  
**Phone: 810-496-0900**

**Ship Location: Grand Blanc Occupational and Convenient Care**  
**2313 E Hill Rd**  
**Grand Blanc, MI 48439**

**Forms**

**Quantity: 100**  
**Paragon Dept No: 64100**  
**Dept Name: Grand Blanc Occupational and Convenient Care**  
**Company Number: 810**

**Order Total Price: 0.00**

**Item Number: MM-117**  
**Item Description: Refusal to Consent to Medical Treatment / Transport**  
**Revision Date: 4/2019**  
**Print: 1 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**

McLaren Medical Group

**REFUSAL OF MEDICAL CARE, TREATMENT, AND/OR TRANSPORTATION**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I understand that complications to my general health may occur if I do not proceed with the recommended treatment. My provider has recommended the following to me: \_\_\_\_\_

**Acknowledgment**

I have received information about the proposed treatment. I have discussed my treatment with my provider and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, the alternate treatment options, and the risks of the recommended treatment, and my refusal of care.

I personally assume the risks and consequences of my refusal, and release the provider and McLaren Medical Group from any or all liability for all effects which may result from my refusal to consent to the performance of the proposed treatment.

I have been advised that medical care on my behalf is necessary, and that refusal of care and assistance could be hazardous to my health, and under certain circumstances, include disability or death.

I acknowledge that I may have a medical problem which may require additional medical attention, and that an ambulance is available to transport me to the hospital. Instead, I elect to seek alternative medical care and refuse further evaluation, treatment and transport.

I acknowledge that I have read this document in its entirety.

I do NOT wish to proceed with the recommended treatment against the advice of the provider.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Guardian

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Provider

**FOR MINORS OR PERSONS WHO HAVE GUARDIANS:** I am the patient's legal guardian.

My relationship to the patient is \_\_\_\_\_ I am hereby acting on behalf of the patient.

I have read the above information and refuse medical care, treatment and/or transportation on behalf of the patient.

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Name (print): \_\_\_\_\_ Guardian's Full Address & Phone No: \_\_\_\_\_

If you change your mind or your condition changes, call 911 and go to the nearest hospital emergency room.

Reference:

Date of Birth: