



NSW Health

FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

Facility:

D.O.B. ____/____/____

M.O.

ADDRESS

PROCEDURE / TREATMENT REFUSAL ACKNOWLEDGEMENT (PATIENT WITH CAPACITY)

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Refusal to follow clinical recommendations

To be used in conjunction with local procedure and the NSW Health Consent Manual

PROVISION OF INFORMATION TO PATIENT

To be completed by most senior available Health Practitioner

I, consider this patient has the decision making capacity to refuse the proposed treatment and I have discussed with this patient the nature of the proposed treatment.

NAME AND DESIGNATION OF MOST SENIOR AVAILABLE HEALTH PRACTITIONER

I have informed this patient of the matters as detailed below including the proposed treatment, its nature and likely results:

I have also discussed with the patient the material risks and the possible consequences of refusing the treatment (must be completed):

I have also discussed with the patient the material risks and the possible consequences of refusing the treatment (must be completed):

SIGNATURE OF MOST SENIOR AVAILABLE HEALTH PRACTITIONER

DATE

TIME

Interpreter*

PRINT NAME

SIGNATURE

DATE

TIME

Emp ID/Prov No.

Where there is doubt about the capacity of a patient to refuse treatment, or there may be serious consequences for a minor seeking to refuse treatment, refer to the Consent Manual, escalate to a more senior colleague, or seek legal advice.

PATIENT REFUSAL

To be completed by patient

..... and I have discussed my present condition.

NAME AND DESIGNATION OF MOST SENIOR AVAILABLE HEALTH PRACTITIONER

I have had the nature of the proposed treatment explained to me as well as the potential consequences if I refuse the treatment.

I have had the opportunity to ask questions and I understand the answers I have been given.

I have been given the opportunity to consult with another health practitioner for a further opinion*.

If so, name of health practitioner providing second opinion:

My decision is informed and I understand the nature and reasons for the proposed treatment. I accept the risks and likely consequences arising as a result of my decision to refuse the proposed treatment.

I hereby do not consent to the above recommended treatment

SIGNATURE OF PATIENT

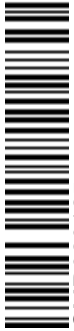
DATE

TIME

AM/PM

If the patient refuses to sign the form, place the partially completed form in the health care record and document in the progress/clinical notes.

* Delete where not applicable



SMR020125

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

NH700070 201218

NO WRITING

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PROCEDURE / TREATMENT REFUSAL ACKNOWLEDGEMENT (PATIENT WITH CAPACITY)

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