NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

PROCEDURE / TREATMENT REFUSAL ACKNOWLEDGEMENT (PATIENT WITH CAPACITY)

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
NAME AND DESIGNATION OF MOST SENIOR AVAILABLE HEALTH PRACTITIONER
capacity to refuse the proposed treatment and I have discussed with this patient the nature of the proposed treatment.

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):

.....

.....

.... /..... /..... ..... : .....
SIGNATURE OF MOST SENIOR AVAILABLE HEALTH PRACTITIONER — DATE — TIME

Interpreter* .... /..... /20..... ..... : ....
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

.... /..... /..... ..... : ..... AM/PM
SIGNATURE OF PATIENT — DATE — TIME

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

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NO WRITING

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PROCEDURE / TREATMENT REFUSAL ACKNOWLEDGEMENT (PATIENT WITH CAPACITY) SMR020.125

SMR020125

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