REFUSAL OF MEDICAL TREATMENT FORM

NAME: ______________________________ ID #: ________________ DOB: ______________

DATE: ________________ TIME: ________________

1. **I refuse to authorize the following upon myself, ____:**
   (Patient's Printed Name)

   ☐ Intake Vital Signs ☐ Detox Vital Signs ☐ Blood Pressure Check ☐ Blood Sugar Check ☐ Blood Draw for Labs

   ☐ Practitioner Sick Call ☐ Nurse Sick Call ☐ Wound Care ☐ Other: ______________________________

   ☐ Medication (Name and Dose): ____

2. **Reason (the "WHY") for refusal: ____**

3. **I have been advised of the possible complications of my refusal:**
   - ☐ Delays in medical assessment, diagnosis, and treatment.
   - ☐ Delays in obtaining information needed to change the medical treatment plan or medications.
   - ☐ Delays in achieving a therapeutic level of medication to treat a medical or mental health problem.
   - ☐ Life-threatening complications including, but not limited to:
     - Stroke
     - Heart attack
     - Metabolic crisis
     - Organ failure
     - Vision problems
     - Wound healing
     - Infection
   - ☐ Any other unforeseen complications because of refusal up to, and including, DEATH.

4. **I hereby release the practitioner(s), nurse(s), custody staff, and the jail from all liability for injury to my health caused by my refusal.**

5. **I certify that I have read and understand the above information, that the above was explained to me, and that the document was filled out completely before I signed it.**

____

Patient Signature Date

____

Witness Signature Date

____

Witness Signature #2 (requested only if patient refuses to sign) Date

____

Practitioner Acknowledgment Date