Patient Refusal Form

Women's Health Connection Program (WHC) in Partnership with Access to Healthcare Network (AHN)

Date (MM/DD/YY):

Patient name:

Date of birth (MM/DD/YY):

SSN:

I, have been informed by my doctor that I should have the procedure/treatment described below.

Name of procedure/treatment:

I am refusing this procedure/treatment because:

* I have had the need for this procedure/treatment explained to me.
* I know that not having this procedure/treatment at this time is against my doctor's advice and may be harmful to my health. My abnormality may lead to cancer if I do not have this procedure/treatment.
* I know what this procedure/treatment is for. I know why I need it. I know how it is done.
* I know that signing this form does not stop me from having this procedure/treatment done later.
* I know how to get money to help me pay for the procedure/treatment.
* I know that I am still part of the Women's Health Connection program.
* I have read all of the information above and know what it means. I am choosing to refuse the above procedure/treatment at this time.

Patient signature: Date (MM/DD/YY):

Submitted by: Date (MM/DD/YY):

State ID#:

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1-844-469-4934 | accesstohealthcare.org
4001 S. Virginia Street, Suite F | Reno, NV 89502