Karvinská
hornická
nemocnice a. s.

Name and surname:

Address:

Birth Registration No.:

Insurance company:

Record of refusal of healthcare provision

TREATMENT REFUSAL FORM

Workplace stamp:

Date: ***Time:***

I hereby confirm, with my signature, that, as a patient of the stated hospital, I refuse the provision of the recommended healthcare. I was repeatedly and **sufficiently** informed about my medical condition and about the possible consequences of my decision.

I was allowed to ask questions; these questions were answered. I understood the information provided.

I am fully aware that this attitude may seriously damage my health or even endanger my life.

I was instructed that if necessary I could return to the hospital at any time.

_____ _____

patient name tag and signature of the nurse

_____

Name and signature of the attending physician