**PATIENT REFUSAL OF MEDICAL TREATMENT**

***PENOLAKAN PASIEN TERHADAP PENGOBATAN MEDIS***

***Visit Id :***

Date/*Tanggal* :

Time/*Waktu* :

I/*saya* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emp no/*No karyawan* \_\_\_\_\_\_\_\_\_\_\_\_ Dept /*departemen*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Refuse to have treatment by*/ Menolak untuk mendapatkan pengobatan dari*  \_\_\_\_\_\_\_\_\_\_\_\_

I Recognize I have been Informed of the risk and possible about the consequences of the refusing of medical treatment of that is happened the highest risk (death)

*Saya Mengakui Saya telah diberitahu tentang risiko dan kemungkinan konsekuensi dari penolakan perawatan medis yang terjadi dengan risiko tertinggi (kematian)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From this statement, the result of my refusal treatment not the responsibility of all PTMI medical teams including the doctor.

*Dari pernyataan ini, hasil penolakan pengobatan saya bukan tanggung jawab seluruh tim medis PTMI termasuk dokter.*

By signing this form, I recognize and responsible about the statement that I write

*Dengan ini, saya mengakui dan bertanggung jawab atas pernyataan yang saya tulis*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee/ patient signature Date & time/ *Tanggal & Waktu*

*Tandatangan karyawan/ pasien*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness / *Saksi*  Date & time/ *Tanggal & Waktu*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness / *Saksi* Date & time/ *Tanggal & Waktu*