Tasmanian Government

REFUSAL TO CONSENT TO MEDICAL PROCEDURE / TREATMENT

FACILITY / WARD _____

TASMANIAN HEALTH ORGANISATION – North

M.R.N.

LABEL

SURNAME ..... D.O.B.....

OTHER NAMES ..... SEX

This form is to be completed giving due consideration to the policy "Consent to Medical Procedures and Treatment".

FT182400

PATIENT TO COMPLETE

I have been advised by _____ that it is necessary to

NAME OF DOCTOR

undergo the following medical procedure/treatment

_____

NAME OF PROCEDURE/TREATMENT

The nature and the effect of this procedure/treatment have been explained to me. Although failure to follow the medical advice which I have received may seriously endanger my life or health, I nevertheless refuse to submit to the recommended treatment. I take upon myself the risks and consequences involved and in consideration of the care and treatment now and in the future given me by the hospital, the medical and other staff including the time and care involved in the said explanation I release the abovenamed doctor, the hospital and its staff from any liability for consequences of my refusal and waive any claim which I might otherwise have had in consequence of the recommended medical procedure/ treatment not being undertaken.

SIGNATURE OF PATIENT	PRINT NAME OF PATIENT	DATE

SIGNATURE OF WITNESS	PRINT NAME OF WITNESS	DATE

(ii) Confirmation

I ....., have explained to.....

NAME OF DOCTOR NAME OF PATIENT

that the following consequences may result from the patient's refusal to undergo procedure/treatment/operation

.....

.....

In my opinion he/she understood this explanation.

Dated this ..... day of ..... 20 .....

Signature of Doctor ..... Designation .....

eg: REGISTRAR, RMO

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REFUSAL TO CONSENT TO MEDICAL PROCEDURE / TREATMENT 2A

DISCHARGE AT OWN RISK – REFUSAL TO PERMIT BLOOD TRANSFUSION

REFUSAL TO PERMIT BLOOD TRANSFUSION

NOTE: Both sections must be completed

(i) Refusal to consent

I, ... (GIVEN NAME) ..... (SURNAME), hereby expressly withhold my consent to and forbid under any circumstances the administration of blood or its derivatives to me during this stay in hospital.

The possibilities of serious effects have been explained to me and I understand them.

I release the Hospital and its servants and agents from liability for any damage or injury which may in any way arise out of, or in connection with, this my refusal to consent to the administration of blood or its derivatives.

Dated this ..... day of ..... 20 .....

Signed ..... *Relationship to Patient .....

Signature of Witness ..... Name of Witness .....

(ii) Confirmation

I, ... (NAME OF DOCTOR), have described to the †patient/person legally responsible for the patient the nature and effect of the above refusal to consent to the administration of blood or its derivatives. In my opinion, †he/she understood this explanation.

Dated this ..... day of ..... 20 .....

Signature of Doctor ..... Designation ..... (eg: RMO, REGISTRAR)

*Relationship to patient – e.g. myself, my wife.
†Strike out where inapplicable

DISCHARGE AT OWN RISK

I, ... (GIVEN NAME) ..... (SURNAME), am removing

..... (*RELATIONSHIP TO SIGNATORY) from this hospital at my own insistence and against the advice of the doctor and hospital staff employed in a facility controlled by the Hospital. I have been informed by them of the dangers of leaving the hospital at this time. In consideration of the care and treatment continuously given me by the Hospital, the medical and other staff including the time and care involved in informing me of the dangers of leaving the hospital at this time, I hereby release the Hospital and its servants and agents, and undertake to indemnify each of them, from any liability which may arise out of or in connection with this decision.

Dated this ..... day of ..... 20 ..... at ..... a.m. p.m.

Signed ..... *Relationship to Signatory .....

Signature of Witness ..... Name of Witness .....

*Relationship to Signatory – e.g. myself, my wife, my child