PATIENT REFUSAL FORM

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

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 the 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 the 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 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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