WOMEN'S HEALTH CONNECTION (WHC)
PATIENT REFUSAL FORM

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

PATIENT INFORMATION	
Name:	Today's date (mm/dd/yyyy):
DOB (mm/dd/yyyy):	SSN:

PROCEDURE/TREATMENT INFORMATION
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:

ACKNOWLEDGMENT OF RISKS/UNDERSTANDING

- 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/yyyy):

STAFF USE ONLY	
Submitted by:	Date (mm/dd/yyyy):
State ID#:	

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