**Against Medical Treatment Advice Form**

**Patient Information:**

* **Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Healthcare Provider Information:**

* **Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Clinic/Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of Advised Treatment:**

* **Treatment or Procedure Recommended:**

**Reason for Declining Treatment:**

* **State the reason for refusing the treatment advice:**

**Risks Associated with Refusal:  
I have been informed of the risks associated with declining the recommended treatment, which may include:  
☐ Progression of illness or disease  
☐ Permanent damage or loss of function  
☐ Risk of death or other severe complications  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Acknowledgment and Consent:  
I confirm that I fully understand the risks of refusing treatment and accept all responsibility for any consequences resulting from my decision.  
Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_**