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: _____