

**CONSENT FORM 3**

**INFORMED REFUSAL**

**Patient Details (or pre- printed label)**

|  |  |
| --- | --- |
| Patient’s surname/family name |  |
| Patient’s first names |  |
| Date of birth |  |
| Responsible health professional |  |
| Job title |  |
| Service |  |
| NHS number (or other identifier) |  |
| Gender  |  |
| Special requirements (e.g. other language/other communication method)  |  |

**\*\* To be retained in patients health records\*\***

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| **STATEMENT OF HEALTH PROFESSIONAL**To be filled in by health professional with appropriate knowledge of procedure/course of treatment, as specified in the Trusts Consent to Care and/or Treatment Policy. |
| Details of proposed procedure or course of treatment (include brief explanation if medical term not clear)  |  |
| The procedure will involve the use of the anaesthesia  | General or regional  |  |
| Local anaesthesia |  |
| Sedation |  |
| I have explained the care/and or treatment to the patient as detailed below  |
| The purpose and nature of the care/treatment: |  |
| The intended benefits which include: |  |
| Any significant risks which are: |  |
| Any extra procedures which may become necessary during the procedure. Which may include: |  |
| The following leaflet/tape has been provided (if applicable) |  |
| Please provide details of any further information given as requested by the patient  |  |
| **Signed Name** | **Date**  |
|  |  |
| **(PRINT Name)**  | **Date** |
|  |  |
| **Contact details (if patient wishes to discuss options later)** |  |
| **STATEMENT OF INTERPRETER (where appropriate)**I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand. |
| **Signed Name** | **Date** |
|  |  |
| **(PRINT Name)**  | **Date** |
|  |  |
| **Copy accepted by patient Yes/No** (please Circle) |

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| **STATEMENT OF PATIENT** |
| An adult aged 16 + with capacity has the right to refuse care or treatment they do not wish to receive, even if refusing treatment would result in their death, or the death of their unborn child, except in certain circumstances as defined in the MHA 1983 or in exceptional circumstances under common law |
| **I acknowledge** that my health professional has recommended the above care and/or treatment to be given  |  |
| **I confirm** that they have explained the potential benefits and risks of receiving the treatment |  |
| **I confirm** they have explained to me the potential risk of refusing the care or treatment as detailed below, which I fully understand  |  |
| **Risks associated with non-concordance**  |  |
| **Having taken into account the information given to me I have made an informed decision and refuse consent to the proposed care/treatment**.  |  |
| I understand that I can discuss the care/treatment at any time in the future with my health professional  |  |
| **Patients signature**  | **Date** |
|  |  |
| **(PRINT Name)** | **Date** |
|  |  |
| **A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here.** |
| **Witness signature**  | **Date** |
|  |  |
| **(PRINT Name)** | **Relationship**  |
|  |  |