

Central Florida
Foot and Ankle Center, LLC
101 6th ST NW
Winter Haven, FL 33881
www.FLFootandAnkle.com

Refusal of Care Form

Patient: _____ Age: _____

Medical condition at issue: _____

Person being advised (if other than patient): _____

Physician advising: _____

My physician, named above, has advised that I, or an individual for whom I am a legal guardian, undergo the following test(s), treatment(s) or procedure(s):

My physician has explained the above test(s), treatment(s) or procedure(s) to me. In doing so, my physician has explained to me the risks and benefits of his or her recommendation; the alternatives, if any, to this recommendation; and the risks and consequences of not receiving the recommended test(s), treatment(s) or procedure(s). Specifically, my physician has advised me of the following risks in refusing the above recommended medical care: _____

I have had the opportunity to ask questions about the proposed recommendation and the risks associated with my refusal of care, and my physician has answered my questions I have asked to my satisfaction.

Notwithstanding the recommendation of my physician and with the knowledge I have regarding this recommendation, I have decided NOT to accept/permit the test(s), treatment(s) or procedure(s) listed above. I understand that my refusal of this recommended medical care may seriously affect my health or the health of the person under my guardianship.

Patient/Guardian Date Time

I have recommended the above medical care for this patient. To the best of my knowledge, the patient or patients guardian understands the risks associated with refusal of the above care, including the specific risks listed above.

Patient/Guardian Date Time