WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

DECLINATION OF MEDICAL TREATMENT

Consent Admission or Treatment

Patient Identification Area

Physician to complete

The physician signing this form is recommending that I receive the following medical treatment:

_____

_____

[Check one]

❏ The potential risks that could result from declining the recommended medical treatment include, but are not limited to: _____

_____

_____

❏ The risks associated with the following medical diagnosis have been reviewed with me as outlined in provided information sheet [check if applicable]:

- ❏ Prelabor rupture of membranes (6080−211)
- ❏ Hypertension in pregnancy (6080−374)
- ❏ Gestational diabetes (6080−377)
- ❏ Trial of Labor After Cesarean (6080−373)
- ❏ Going past your due date (6080−375)
- ❏ Cesarean delivery (6080−379)

_____ _____

OB Provider Printed Name OB Provider Signature

Patient to complete

✓ I have refused to consent to such treatment.

✓ I acknowledge that the physician has explained the treatment to me and that I understand the potential risks that could result from declining the recommended medical treatment and the reasonable risks and benefits of the recommended medical treatment.

✓ I acknowledge that I have refused to consent to the recommended medical treatment despite those risks and benefits. I hereby assume any and all responsibility for declining the recommended medical treatment.

✓ I have read this entire document and understand it. I have been given the opportunity to ask any questions and my questions have been answered to my satisfaction.

_____ _____ _____

Patient or Guardian Printed Name Patient or Guardian Signature Date/Time

_____

Relationship if other than patient