DECLINATION OF MEDICAL TREATMENT

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)  ☐ Trial of Labor After Cesarean (6080–373)

☐ Hypertension in pregnancy (6080–374)  ☐ Going past your due date (6080–375)

☐ Gestational diabetes (6080–377)  ☐ 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 ____________________________