island health care island hospice THAGroup independent life at home RightHealth®

INFORMED REFUSAL FORM

Your physician, _____, has recommended home health care to provide the following services and treatments:

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Home Aide

In order to provide:

☐ Disease Management ☐ Medication Management ☐ Wound Care ☐ Telemetry
☐ Functional Improvement ☐ Fall Prevention ☐ Strength/Endurance Training
☐ Other: _____

_____, _____ has explained to me that the potential benefits
Clinician's Name *Discipline*
of the care include:

and that the risk of not receiving home health services are:

Despite my physician's recommendation, I am declining to consent to home health care services at this time. The clinician has explained to me the risks associated with not following through with the recommended treatments, plans of care and services. By signing this document, I acknowledge that I have had an opportunity to discuss any and all questions related to the recommended treatment.

_____ _____
Patient/Representative Signature Date & Time

_____
Representative Relation to Patient

☐ The patient/authorized individual has read this form or had it read to him/her.
☐ The patient/authorized individual states that he/she understands this information.
☐ The patient/authorized individual has no further questions.

_____ _____
Clinician's Signature Date & Time