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Client Informed Refusal

4/2022

Reasonable accommodations made for persons with disabilities. TDD (800) 833-7352. The Nebraska Department of Health and Human Services provides language assistance at no cost to limited English proficient persons who seek our services.

Directions for form:

1. Client must fill out Section 1.
2. Providers must fill out Section 2 or 3

Section 1:

Date ____/____/____

I, _____ have been informed by my healthcare provider, that I should
(please print your name)

have this test/treatment below. This test/treatment is: _____

(please print in your own words, the name of the test/treatment and why it is being done)

If I do not get this test/treatment I know these things may happen to me: _____

(please print in your own words what can happen if the test/treatment is not done)

- I have had the need for this test/treatment explained to me.
- I know that **NOT** having this test/treatment at this time, is against my healthcare provider's advice and may be harmful to my health. My abnormal test results may be a sign of a potential serious medical condition, including cancer.
- I know what this test/treatment is for. I know why I need it. I know how it is done.
- I know that signing this form does not stop me from having this looked at and treated later.
- I know how to get money to help me pay for the test/treatment.
- I know that I am still a part of Every Woman Matters (EWM) if I am a female over 40 years of age.
- I know that I can reapply later to EWM if I am a female and under 40 years of age.
- I know that I can reapply to the Nebraska Colon Cancer Screening Program (NCP), if I am a male or female 45 years of age or older.
- I have read all the information above and know what it means. I am choosing to refuse the above test/treatment at this time.

Client Signature _____ Date ____/____/____

Section 2:

Submitted by: Clinic Case Manager EWM/NCP Central Office

_____ Date ____/____/____

Facility/Clinic/Agency Information - clinician name, clinic name, city name (do not abbreviate)

Portion below to be completed ONLY if client unable to write or has language barrier.

If client unable to write information themselves; the client will dictate the information and the form should be witnessed by two individuals.

Dictated by _____ Date ____/____/____
Please Print Client Name

Written by _____ Date ____/____/____
Person taking the dictation

Witnessed by:

1. _____ Date ____/____/____

2. _____ Date ____/____/____

Interpreted by: _____ Date ____/____/____
If Interpreter Needed

SSN#:

Name of Procedure/Treatment:

Client Name

DOB:



Service Provider Documentation

Directions for form:

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Section 3:

Provider has assured that the client has enough information to make an informed decision by:

Client Informed Refusal given to client: Yes No on Date ____/____/____
Date Required

Client Informed Refusal given to client by: Personal Contact / In the Office
 Phone Contact
 Postal Contact

Client returned Client Informed Refusal incomplete.

Client failed to return a signed Client Informed Refusal.

Attempts were made to give information to the client regarding:

- Diagnostic Services Diagnosis
- Treatment Services Treatment

Provider is unsure if the client has or is able to make an informed decision due to one or more of the following reason(s):

- No verbal communication with client Low literacy level
- Language / Translation issues Mental / Emotional disability
- Visual / Hearing impairment

Date ____/____/____
Facility/Clinic/Agency Information - clinician name, clinic name, city name (do not abbreviate)

Name of Person completing this form: _____

Date ____/____/____
Facility/Clinic/Agency Information - clinician name, clinic name, city name (do not abbreviate)

Client Name _____
DOB: _____
SSN#: _____
Name of Procedure/Treatment: _____