Client Informed Refusal

Version: November 2015

301 Centennial Mall South, P.O. Box 94817
Lincoln, NE 68509-4817
Phone: 1-800-532-2227 Fax: (402) 471-0913

Directions for form:

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

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.

SSN#: _____ Name of Procedure/Treatment: _____

Client Name _____ DOB: _____

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 abnormality 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 evaluation/procedure/treatment done 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 50 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 herself; 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

Complete reverse side only if unable to obtain a signed Client Informed Refusal

Every Woman Matters

Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Colon Cancer Screening Program

Service Provider Documentation

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1. Client must fill out Section 1.
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Client Name _____ DOB: _____ SSN#: _____ Name of Procedure/Treatment: _____

Section 3:

Provider has insured 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)***

Nebraska Department of Health and Human Services ~ Women's and Men's Health Programs
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