REFUSAL OF RECOMMENDED EMERGENCY TREATMENT

Patient Name: _____ DOB: _____

Name of Person Completing Form (if not patient):

_____

Relationship to Patient: _____ Telephone #: _____

Date: _____ Time: _____ Location: _____

Dr. _____ has recommended that I undergo the following emergency dental/maxillofacial test, treatment, or surgical procedure:

_____

_____

_____

Acknowledgments

I acknowledge the following:

- My oral/maxillofacial surgeon or physician has explained my medical condition to me.
- The reasons for and/or the purpose of the recommended test/treatment/procedure have been explained to me.
- The nature of the recommended test/treatment/procedure has been explained to me.
- The risks and benefits of the recommended test/treatment/procedure have been explained to me.
- The alternatives (including non-treatment) to the recommended test/treatment/procedure have been explained to me.
- My questions have been answered in my language in a way that I can understand to my satisfaction.

Risks of Refusal

My surgeon/physician has explained the risks of refusing the recommended test/treatment/procedure. They include, but are not limited to:

- Severe, unmanageable pain and prolonged discomfort.
- Spread of severe infection to the face, neck, airway, or bloodstream (sepsis).

- Compromised airway or difficulty breathing (which can be a life-threatening emergency).
- Permanent facial deformity, nerve damage, or irreversible loss of teeth and jaw bone.
- I understand there could be risks of refusing the recommended test/treatment/procedure that are not yet known.

Decision to Refuse

Although my refusal to follow Dr. _____'s advice and undergo the recommended test/treatment/procedure **could seriously impair my health or even result in death**, I choose to refuse the recommended test/treatment/procedure and accept the risks and consequences of my decision.

I understand that I can change this decision at any time by contacting Dr. _____ and taking action to cancel this refusal.

_____ _____

Patient Signature (or Person Completing Form) Date

_____ _____

Witness Signature Date

_____ _____

Surgeon / Physician Signature Date