



REFUSAL TO ACCEPT REFERRAL/RECOMMENDED FOLLOW-UP

NORTH DAKOTA DEPARTMENT OF HEALTH

FAMILY PLANNING PROGRAM

SFN 59153 (02-2016)

Agency		Date	
Name of Client		Date of Birth	
Address	City	State	ZIP Code
Chart Number	Telephone Number		
Reason for Referral/Recommended Follow-up			
Referred By			
Additional Information (contraceptive method, other test results, significant gyn history, etc.)			
I have been advised to seek referral/recommended follow-up because of the above-mentioned reason(s) and have been offered a list of health care facilities from which to choose. Even though it has been recommended that I do so, I do not plan to get referral care for the following reason(s):			
The following possible risks of not accepting or acting upon the referral/follow-up have been explained to me			

I hereby release _____ and its medical staff and employees from any and all liability arising out of or connected with my decision not to follow the above medical recommendation.

Initial _____

Client Signature	Date
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I witness the fact that the client signed above and said she/he read and understood the same.

Witness Signature	Date
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Employee Name	Employer
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I verify that the above-stated information was provided to _____ and that she/he refused to sign this Refusal to Accept Referral form.

Employee Signature	Date
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