OKLAHOMA DEPARTMENT OF CORRECTIONS
WAIVER OF TREATMENT/EVALUATION
(Form will be completed in its entirety)

Facility _____ **Date** _____ **Time** _____

I certify that I am refusing to consent to the following treatment/procedure/diagnostic test/medication/outside referral/laboratory at my own insistence and against the advice of the health care provider.

1. Refusal for: (Check all that Apply)

   Scheduled Appointment: ☐ Chronic Clinic ☐ Physical Exam ☐ Follow-up Exam ☐ Eye Exam ☐ Laboratory ☐ Dental

   ☐ Outside Specialty Appointment "Specify Clinic" _____

   If the refusal is for an outside specialty clinic appointment based on a medical condition preventing travel or a scheduled family visit, does the inmate want the outside specialty clinic appointment rescheduled: ❑ Yes ❑ No

   ☐ Diagnostic Test "Specify" _____ ☐ Scheduled Procedure "Specify" _____

   ☐ Medication "Specify" _____

   Other: "Specify" _____

2. Reason for the refusal: (Check all that Apply)

   ☐ I no longer want evaluation or treatment of my symptoms/condition.
   ☐ I have decided to wait until after release from ODOC to pursue evaluation and treatment.

   Explain: _____

   _____

3. I have been informed by a Health Care Provider, RN, LPN or QMHP of the risk's attendant to my refusal. These include:

   Potential avoidable premature death, pain and suffering, progressive disability, worsening health, new illnesses, complications of existing conditions, need for surgeries, procedures or hospitalizations. Current medications may be discontinued due to noncompliance with needed ongoing follow up of treatment**.** _____

   Other: _____

   _____

4. During the clinical interview which included counseling and education, the Health Care Provider, RN or LPN has given me the opportunity to ask questions and has answered my questions.

5. I assume full responsibility for any results caused by my decision and I hereby release the institution, its employees, officers, and the provider from all legal responsibility and liability.

6. I certify that I am of sound mind and have read, or had read to me, and fully understand the above information concerning my refusal to accept treatment/evaluation and have had an opportunity to ask questions before I affix my signature.

7. I understand I may retract my decision and receive the treatment/procedure/diagnostic test/medication/outside referral/laboratory, although consequences due to the delay may result.

Inmate Signature: _____ Date: _____

Health Care Provider/RN/LPN/QMHP: _____ Date: _____

If the offender refuses to sign such a statement, he/she cannot be forced to do so legally nor may release be withheld until the offender signs. If this occurs, the form will be filled out, witnessed by two facility personnel and the statement documented on the form, **"SIGNATURE REFUSED."**

Witness Signature: _____ Date: _____

Inmate Name: (Last, First) DOC Number