



## DECLINE CONSENT FORM

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Procedure requested \_\_\_\_\_

### Patient Consent

By signing this form you are indicating that you have been consulted by a doctor, and have had all the risks explained to you by a Technician or Radiologist. By signing this form you are also indicating you understand that by declining the procedure, you may compromise the accuracy of diagnosis.

I understand and accept the risks involved in for not proceeding with the procedure. I hereby decline the above procedure.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient)

Name \_\_\_\_\_  
(Interpreter if present)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Interpreter if present)