Refusal to Permit Administration of Rho(D) Immune Globulin

PATIENT _____ **AGE** _____

I have been advised and it has been recommended by my physician Dr. _____ that I, or a person for whom I am the legal guardian, should receive Rho(D) immune globulin.

My physician has satisfactorily explained the above treatment to me, the risks and benefits of this recommendation, the alternatives to this recommendation and the probable consequences of not receiving this treatment. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

Notwithstanding the recommendation of my physician and with the knowledge I have regarding this recommendation, I have decided NOT to receive Rho(D) immune globulin. I understand that my failure to follow my physician's advice may seriously affect my health or the health of the person under my guardianship.

By signing below, I assume responsibility for all the risks and consequences of my refusal. I also release Dr. _____ and other persons participating in my care or that of the person under my guardianship from all responsibility for any unfavorable or bad results that may occur as a result of my refusal to accept/permit the proposed recommendation.

_____	_____	_____
Patient/Guardian	Date	Time
_____	_____	_____
Physician	Date	Time
_____	_____	
Witness	If signed by other than patient, indicate relationship.	

If there are any questions on this form, call the Hospital and Outpatient Services Unit at 850-412-4549. This form must be retained in the medical record at the clinic.