STATEMENT OF REFUSAL OF EXAMINATION AND TREATMENT

Dental Hospital, Faculty of Dentistry, Prince of Songkla University

Date.....Month.....Year.....

I, (Mr. / Mrs. / Ms.) .....aged .....years, holder of ☐ a National Identification Card ☐ Passport ☐ a Government Official Identification Card ☐ other identification (specify) .....No. .....
Affiliation.....acting as ☐ the patient ☐ the patient's authorized representative, in the capacity of..... of the patient
Patient's name (Miss/Master/Mr./Mrs./Ms.) .....HN .....

I have been informed by a physician/ dentist of the Dental Hospital of the necessity of the examination, treatment and procedures, as well as the adverse consequences that may arise if I do not undergo them. **Nevertheless, I hereby declare my refusal to undergo the said examination, treatment and procedures.**

Should any harm or adverse consequences occur to the patient, I shall not regard such harm or consequences as constituting any fault or deficiency on the part of the physician/dentist or any staff member of the Dental Hospital.

Signature.....
(.....)
Attending Dentist

Signature.....
(.....)
Patient/ Person Authorized to Consent on Behalf of the Patient
Relationship to the patient: .....

Signature.....
(.....)
Witness

Signature.....
(.....)
Witness

Date ..... Time.....

Notes

1. If the patient attends alone, enter “ Patient attended alone” in the witness signature field and countersign the entry.
2. If the patient is under 18 years of age, a parent or guardian must sign in the field for “Patient / Person Authorized to Consent on Behalf of the Patient”.