



# PATIENT REFUSAL FORM

Please Print

Keep on file in clinic

Patient CHR Number \_\_\_\_\_ Date \_\_\_\_\_

**Clinic Name:** \_\_\_\_\_

## REFUSAL INFORMATION

1. Has this patient participated (enrolled) in this surveillance project in the past? (check one)

Yes  No

2. When was the surveillance project information presented to the patient? (Check all that apply)

- Prior to a scheduled visit  
 During a scheduled visit  
 During an unscheduled visit  
 Other (specify) \_\_\_\_\_

3. Who presented the surveillance project information to the patient? (check all that apply)

- Physician  
 Nurse  
 Social Worker  
 Other (Specify) \_\_\_\_\_

4. How was the surveillance project information presented to the patient? (check all that apply)

- Telephone call  
 Discussion with clinic staff during visit  
 Patient given consent form to read  
 Other (Specify) \_\_\_\_\_

5. What part(s) of the surveillance project were (was) not acceptable to the patient? (check all that apply)

- Blood specimen for storage in a bank  
 Venipuncture required  
 Confidentiality concerns  
 Study is not applicable  
 Parent/Legal Guardian unwilling  
 Child refuses assent  
 Other (Specify) \_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
PI/Nurses Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature