



# 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:

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature