Informed Refusal:
Recommendations to the treating dentist

Just as patients should know the risks, benefits, and alternatives of accepting a treatment recommendation, they should also know the potential consequences of refusing a proposed treatment or procedure (e.g., a patient who refuses a recommendation for evaluation or consultation regarding periodontal disease, must understand the potential for continued decline in their overall dental health, increased symptoms, inability to reverse resulting damage, bone loss and serious, potentially life-threatening infection).

All states impose a duty on dentists to obtain a patient’s informed refusal whenever refusal holds potentially serious complications. Depending on the circumstances, dentists should be aware of continuing to treat when the patient’s refusal jeopardizes the possibility for a successful outcome or the patient’s health, in which case terminating care may be the only reasonable option. In any case, a patient’s refusal should be thoroughly documented in the chart, along with the dentist’s attempts to inform the patient of the consequences of refusal. A patient’s refusal for treatment does not allow a dentist to practice below the standard of care (e.g., continued or repeated refusal to have diagnostic radiographs). Patients cannot consent to substandard care, but can refuse treatment recommendations.

If you use the attached informed refusal form, plan to evaluate the patient in a timely manner (3 months, 6 months, 9 months etc.) to ensure his or her oral health is not jeopardized by not receiving the recommended treatment.

If you experience issues with a patient(s) refusing necessary or recommended treatment, please call the Advice Line at 800.733.0634. Analysts are trained to offer suggestions for these scenarios.
Informed Refusal

Patient Name: ________________________________________________________________

Diagnosis: ________________________________________________________________

Dr. ____________________________ has advised me that the following treatment (describe the treatment) ________________________________________________________________

__________________________________________________________________________

test, or evaluation needs to be performed on (name of patient) ____________________________.

I have discussed with Dr. ____________________________ the risks, benefits, and alternatives of this treatment, test or evaluation. The consequences of no treatment, test or evaluation could lead to, but are not limited to: ____________________________ I have had the opportunity to ask any questions I have regarding the treatment, test or evaluation. All of my questions have been answered to my satisfaction, and I hereby confirm that I do not want the treatment, test or evaluation.

I also understand that if refusing this treatment, test or evaluation could lead to a departure in the standard of care, Dr. ____________ may dismiss me from the practice.

_________________________________________________________ Date

Patient’s or Legal Guardian’s/Representative’s Signature

_________________________________________________________ Date

Witness’ Signature Relationship Date

I have explained the nature, purpose, benefits, and alternatives of the proposed treatment, test or evaluation, as well as the risks and consequences of proceeding or not proceeding with the treatment, test or evaluation. I have answered all of the patient’s questions, and I believe the patient/guardian/representative fully understands my answers and explanations.

_________________________________________________________ Date

Dentist’s Signature

PLACE A COPY IN THE PATIENT’S CHART