APPENDIX D

First Nations & Inuit Health Branch
Alberta Region

Statement of Refusal of Service

Client Name: _____
Last Middle First

Gender: _____	Band: _ _ _ _ _ _ _ _ _ _ _
Date of Birth: _____ YYYY/MM/DD	PHN: _ _ _ _ --- _ _ _ _ _

This Statement of refusal must be signed by the client of the age of majority and mental competence.

This is to certify that I, _____
Print Name

Under the care of the nursing/medical staff of

_____
Location

(☐Homecare program, ☐Public Health, and/or ☐Primary care)

Refuse the care services stated below, as offered and judged necessary by said staff of the First Nations & Inuit Health Branch.

- _____
- _____
- _____
- _____

I am making this decision freely in full knowledge of the situation and possible health risks, and I acknowledge that I have been informed of the consequences of my decision and hereby release the facility, Staff and professionals of all responsibility for any ill-effects which may result from my decision.

Signed: _____ Date: _____ YYYY/MM/DD	Witnessed: _____ _____ Name of Witness Date: _____ YYYY/MM/DD
Translators Declaration: I declare that I have faithfully interpreted the above statements to the client and/or the legal guardian of the client Translator: _____ _____ Name of Translator Date: _____ YYYY/MM/DD	*Legal guardian on Behalf of the client:* The client's age is:____ years and is unable to sign due to: _____ Reason(s) Signed: _____ Date: _____ YYYY/MM/DD