



Refused/Lost to Follow Up Form
Every Woman's Life - Virginia Department of Health

Last Name	First Name	MI	SSN (or Alien ID)
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REFUSED

Refused which test/treatment: _____

Indicate Reason:

Fear of Procedure Illness, Injury or Hospitalization Too Busy/Time Conflicts Transportation Problems
 Financial Problems Disagrees with Recommendations Moved Other _____

Case Management Interventions: _____

Client Response: _____

LOST TO FOLLOW UP

Screening Tests Rescreening Tests Diagnostic Tests Treatment

Case Management Interventions:
of Phone Calls: _____ # of Certified Letters: _____

Client Response: _____

Waiver Statement:

I certify that I have been advised as to the need for follow-up medical evaluation or treatment and the consequences of not getting this evaluation or treatment. I have decided to exercise my right to refuse any type of follow-up medical evaluation or treatment.

Signature

_____/_____/_____
Date

Witness Signature

_____/_____/_____
Date