Against Medical Advice Form

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Medical record number: _____ Date: _____ dd / mm / yyyy

HOSPITAL / CLINIC INFORMATION

Facility name: _____ Attending physician: _____

Unit / department: _____

REASON FOR HOSPITAL VISIT / ADMISSION

Specify below:

DESCRIPTION OF PROPOSED TREATMENT

Proposed treatment / procedure:

Risks and benefits of proposed treatment:

Alternatives to proposed treatment:

RISKS OF REFUSING TREATMENT

Risks of refusing treatment

PATIENT'S ACKNOWLEDGEMENT

Acknowledgement:

PATIENT'S DECLARATION

I release the hospital/clinic, its staff, and my healthcare provider from any liability for any adverse effects that may result from my decision to refuse the recommended treatment and leave against medical advice.

Patient's signature:
Date: _____ dd / mm / yyyy

WITNESS INFORMATION

Witness name: _____

Witness signature:
Date: _____ dd / mm / yyyy

PHYSICIAN'S STATEMENT

Statement:

Physician's signature:
Date: _____ dd / mm / yyyy