Against Medical Advice Form

Patient information	
Name:	Date of birth:
Medical record number:	Date:
Hospital / clinic information	
Facility name:	
Attending physician:	Unit / department:
Reason for hospital visit / admission	
Description of proposed treatment	
Proposed treatment / procedure:	
Risks and benefits of proposed treatment:	
Alternatives to proposed treatment:	
Risks of refusing treatment: (check all that apply)	
☐ Worsening of condition ☐ Complications ☐ Permanent injury	☐ Death ☐ Other:

Patient's acknowledgement

I, _____, acknowledge that I have been informed of my current medical condition and the recommended treatment or procedure. I have been explained the potential benefits and risks of the recommended treatment, as well as the risks of refusing such treatment. I have had the opportunity to ask questions and understand the information provided.

I understand that refusing the recommended treatment may result in the worsening of my condition, complications, permanent injury, or death. Despite this, I choose to leave the hospital/clinic and refuse the recommended treatment against the medical advice of my healthcare provider.

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:** _____

Witness information

Witness name & signature: _____ **Date:** _____

Physician's statement

I, _____, have discussed the patient's medical condition, the recommended treatment, and the potential risks of refusing treatment. The patient has indicated an understanding of the information provided and has chosen to refuse the recommended treatment and leave against medical advice.

Physician's signature: _____ **Date:** _____