AGAINST MEDICAL ADVICE (AMA FORM)

This is to certify that I, ________________________________________, a patient at __________________________________________ (fill in name of your hospital), am refusing at my own insistence and without the authority of and against the advice of my attending physician(s) ____________________________________________, request to leave against medical advice.

The medical risks/benefits have been explained to me by a member of the medical staff and I understand those risks.

I hereby release the medical center, its administration, personnel, and my attending and/or resident physician(s) from any responsibility for all consequences, which may result by my leaving under these circumstances.

MEDICAL RISKS

_____Death  _____Additional pain and/or suffering

_____Risks to unborn fetus  _____Permanent disability/disfigurement

_____Other: __________________________________________________

_____________________________________________________________

_____________________________________________________________

MEDICAL BENEFITS

_____History/physical examination, further additional testing and treatment as indicated.

_____Radiological imaging such as:

_____CAT scan  _____X-rays  _____ultrasound (sonogram)

_____Laboratory testing  _____Potentially admission and/or follow-up

_____Medications as indicated for infection, pain, blood pressure, etc.

_____Other: __________________________________________________

Please return at any time for further testing or treatment

Patient Signature ___________________________ Date _______________

Physician Signature ___________________________ Date _______________

Witness ______________________________ Date _______________