

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 _____Potential 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 _____