Discharge Against Medical Advice

Name……...
DOB……..
CHI…… Addressograph label may be used

I …… (name)

Wish to take my discharge*
OR
I wish to discharge my…… *

I understand that this is against the advice and wishes of the consultant in charge or his deputy. I acknowledge that I have been informed of the dangers of doing so and I accept full responsibility for my actions and any consequences arising from them.

Signed ……..

Date ……/……/……..
Patient*/Relationship to patient* ……

I confirm that I have explained to the patient/patients*

…… (state relationship) the dangers that might arise out of his/her* decision to take his/her* own discharge.

Name of Healthcare professional: ……

Signature of Healthcare professional: ……..
Date: ……/……/……..

Name of Witness: ……

Signature of Witness: ……

Designation: ……
Date: …… /……/……
***DELETE AS APPROPRIATE**

Patient refused to sign self discharge form and/or would not wait to speak to medical staff or nursing staff.
Name of Healthcare professional: ……

Signature of Healthcare professional: ……..
Date: ……/……/……..