

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

**DISCHARGE AGAINST
MEDICAL ADVICE
(ADULT WITH CAPACITY)**

I, am removing
GIVEN NAME FAMILY NAME

myself from (Facility) at my own insistence and against the advice of attending doctor, clinical or hospital staff at the Facility. I have been informed by:

.....
NAME AND DESIGNATION OF THE MOST SENIOR AVAILABLE HEALTH PRACTITIONER

of the risks associated with leaving the Facility at this time, which include a deterioration and/or worsening of my condition and health generally. These risks include, but are not limited to:

.....
(IDENTIFY SPECIFIC RISKS OF LEAVING)

I acknowledge that I have been advised that I should remain in the Facility for treatment of my condition. I understand that there are risks to my health and wellbeing if I leave the Facility. Despite this advice, I agree to accept these risks and I wish to discharge myself from the Facility. I agree that the Facility and its staff will not be liable for any harm or damage that may occur due to my decision to leave the Facility.

I have been advised and understand that I should seek medical advice and treatment, including returning to the Facility, should I have any concerns whatsoever in relation to my health / medical condition.

Date:/...../..... Time: : AM/PM

Print name:

Signature:

Interpreter* /...../20..... :
PRINT NAME SIGNATURE DATE TIME Emp ID/Prov No.

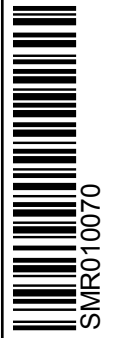
Print name (Health Practitioner):

Designation:

Signature: /...../20..... :
DATE TIME

If the patient refuses to sign the form, place the partially completed form in the health care record and document in the progress /clinical notes.

* Delete where not applicable



Holes Punched as per AS2828.1: 2012
 BINDING MARGIN - NO WRITING

NH700071 07/12/18

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(ADULT WITH CAPACITY)**

SMR010.070