SUNY Downstate Medical Center
UNIVERSITY HOSPITAL OF BROOKLYN

DISCHARGE AGAINST MEDICAL ADVICE

Name:

MR#:

(Please affix label or print)

N.S.:

Service/Dr.:

FORM E

This is to certify that I am over the age of 18 years and I am refusing the services of this facility and I am leaving this facility against the advice of the health care providers at this facility. I acknowledge that I have been informed of the risks, consequences and the dangers to my health and possibly to my life which may result if I leave the facility at this time.

I have been given time to ask questions about my condition and about my decision to leave against medical advice.

I voluntarily assume the risks and accept the consequences of my decision to refuse the services of this facility and I am releasing all of the health care providers, the facility and its staff from any and all liability for ill effects that may result form my leaving this facility.

Patient's Name (Print)	**Signature**	**Date**

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient or the next-of-kin who is assenting to the treatment for the patient, must be obtained.

Health Care Agent/ Guardian (Print)	**Signature/Relationship**	**Date**

WITNESS: *To be signed by a facility employee who is not the patient's health care provider.*
I have witnessed the patient or other appropriate person voluntarily sign this form.

Witness's Name (Print)	**Signature**	**Date**

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FORM E

INTERPRETER/TRANSLATOR: *To be signed by the interpreter/translator if the patient required such assistance*
To the best of my knowledge, the patient understood what was interpreted/translated and voluntarily signed this form.

Interpreter/Translator's Name (Print)	Signature	Date

PHYSICIAN STATEMENT

I have recorded my discussion with the patient/significant other in a progress note concerning the nature and purpose of the operation, treatment(s) or procedure, and the associated risks, consequences and available alternatives. The patient was given the opportunity to ask questions concerning the proposed procedure/treatment and I have answered those questions. The patient/significant other also verbalized his/her understanding of the information given to him/her.

I included conscious sedation in my discussion with the patient/significant other. Yes ☐ No ☐

SIGNATURE OF THE ATTENDING PHYSICIAN

DATE

PRINT NAME AND IDENTIFICATION NUMBER