SELF-DISCHARGE AGAINST MEDICAL ADVICE FORM

TO BE COMPLETED BY THE DOCTOR

I, the undersigned, Mr., Mrs. Ms.....practising as.....at Périgueux Hospital, confirm that Mr., Mrs, Ms (surname, first name, date of birth) :

.....

declines the proposed treatment and declares s/he wishes to leave the establishment.

I have explained the potential medical risks of this action to the patient in a clear, precise and comprehensible manner and the therapeutic alternatives.

- Description of patient's state of health:.....
  .....
  .....
- Treatment proposed by the doctor:.....
  .....
  .....
  .....
- Medical risks linked to the patient's premature departure:.....
  .....
  .....
  .....
  .....
- Other information given (offer of follow-up consultation, possibly with another doctor, proposed transfer to another establishment, proposal to take time to consider the options:
  .....
  .....
  .....

Date : Doctor's signature:

Time :

TO BE COMPLETED BY THE PATIENT

I, the undersigned, Mr., Mrs., Ms. : .....

currently a patient at Périgueux Hospital, decline the treatment proposed by Doctor..... and wish to leave the establishment.

I confirm that I have been informed of the potential medical risks of leaving against medical advice in a clear, precise and comprehensible manner.

I confirm that I have taken this decision of my own free will and that it is against medical advice. I therefore absolve the doctor and the hospital of all liability and any consequences that may arise from my decision.

I understand that even if I sign this document, this does not prevent me from coming back to the hospital should I so wish and that, indeed, this is strongly recommended should I have any questions or the slightest problem.

Date: Patient's (or legal representative's) signature:

Time:

If the patient refuses to sign:

Name and signature of a witness employed by the hospital: