

## AGAINST MEDICAL ADVICE (AMA)

*Consent is a process. It is the communication between a patient and a physician in which each party asks questions and exchanges information, resulting in both the patient and the physician agreeing to specific medical, surgical, pharmaceutical, or diagnostic interventions. It is the obligation of the physician to provide you, the patient, with the information and advice needed to make your healthcare choices. Ultimately, however, the decision for your healthcare rests with you. This form will serve to acknowledge your refusal of the interventions and treatments prescribed by your physician.*

I, \_\_\_\_\_ (Patient's Name) acknowledge that:

1. (Provider) \_\_\_\_\_ has recommended \_\_\_\_\_ for the purpose of \_\_\_\_\_.
2. \_\_\_\_\_ (Patient Initials) I have decided to refuse the recommendation.
3. \_\_\_\_\_ (Patient Initials) My decision has been made after considering both the prescribed treatment as well as any other alternative forms of treatment or diagnostic study for my condition. I fully understand that each of the alternative forms of treatment/diagnostic study has its own potential benefits, risks, and complications.
4. \_\_\_\_\_ (Patient Initials) I completely understand that there are possible risks, complications, and side effects involved in refusing medical treatment. I also understand that it is impossible to list every risk, complication, and/or side effect involved in my refusal, however I have been educated to some of them. They could include, but not be limited to, the following:  
  
\_\_\_\_\_

Although these risks, complications and side effects may be rare, they do sometimes occur and cannot be predicted or prevented by the health care provider. I acknowledge that no guarantee has been made to me about the results of refusing the prescribed treatment/diagnostic study.

5. \_\_\_\_\_ (Patient Initials) I am aware that the potential risks and complications can result in additional medical or surgical treatment, prolonged hospitalization or even permanent disability, severe injuries or death.
6. \_\_\_\_\_ (Patient Initials) I certify that I have read (or had read to me) the entire contents of this form. I acknowledge that the possible risks and consequences created by my refusal to permit the recommended treatment have been fully explained to me. I understand the possible benefits for allowing the recommended treatment and the possible risks and consequences to myself because of my refusal for same.

**Patient / Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*To be signed by Xpress Urgent Care team member*

**Witness' Name** \_\_\_\_\_ **Witness Signature** \_\_\_\_\_