

REFUSAL OF HOSPITAL TRANSFER AGAINST MEDICAL ADVICE (AMA)

Date: [Date]

Patient Name: [Patient Full Name]

Medical Record Number: [MRN Number]

Facility Name: [Current Hospital Name]

I. PHYSICIAN ACKNOWLEDGMENT

I, Dr. [Physician Name], have advised the patient (or their legal representative) that a transfer to [Proposed Receiving Facility] is medically necessary for the following reasons:

[List diagnosis and reasons for transfer]

I have informed the patient of the potential risks of refusing this transfer, which may include, but are not limited to: permanent disability, worsening of condition, or death.

Physician Signature: _____ Date: _____

II. PATIENT ACKNOWLEDGMENT AND RELEASE

I, [Patient or Representative Name], acknowledge that I have been informed by the medical staff of the necessity of a transfer to another medical facility. I understand the medical reasons for this transfer and the specific risks associated with refusing it.

Despite these warnings, I am choosing to refuse the transfer. I assume all responsibility for any physical or mental consequences resulting from my decision. I hereby release [Hospital Name], its staff, and the attending physicians from any liability or responsibility for any injury or ill effects that may result from my refusal to be transferred.

Patient/Representative Signature: _____ Date: _____

Relationship (if not patient): _____

III. WITNESS ACKNOWLEDGMENT

I was present during the discussion of the risks of refusing transfer and witnessed the signing of this form.

Witness Name: [Witness Name]

Witness Signature: _____ Date: _____