Date: [Date]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

AGAINST MEDICAL ADVICE (AMA) DISCHARGE DOCUMENTATION

1. CLINICAL STATUS AND RECOMMENDATION

The patient was admitted on [Admission Date] for [Primary Diagnosis/Reason for Admission]. The clinical team currently recommends continued inpatient psychiatric treatment for the following reasons: [List clinical reasons, e.g., stabilization of symptoms, medication adjustment, risk monitoring].

2. PATIENT REQUEST

The patient has expressed a desire to be discharged from this facility effective [Time] on [Date]. The patient is choosing to leave prior to the completion of the recommended treatment plan.

3. RISKS OF PREMATURE DISCHARGE

The patient and/or legal guardian has been informed of the potential risks of leaving the hospital against medical advice, which may include, but are not limited to:

- Worsening of psychiatric symptoms (e.g., depression, anxiety, psychosis).
- Increased risk of self-harm or suicidal ideation.
- Increased risk of harm to others.
- Inability to function in daily life or maintain self-care.
- Physical health complications related to the psychiatric condition.
- Relapse or increased severity of substance use disorders.

4. CAPACITY ASSESSMENT

The patient has been assessed and, at this time, appears to possess the capacity to understand the risks and benefits of this decision. The patient is not currently meeting the criteria for involuntary commitment under state law.

5. DISCHARGE PLAN AND FOLLOW-UP

Despite leaving AMA, the following resources have been provided:

- Prescriptions: [List medications or state "None provided"]
- Follow-up Appointment: [Provider Name/Date/Time]
- Crisis Resources: [Emergency Hotline/Nearest Emergency Room]

6. PATIENT ACKNOWLEDGMENT

I, [Patient Name], acknowledge that I have been informed of the risks of leaving against medical advice. I accept full responsibility for my health and safety upon departure.

_____

Patient/Guardian Signature

_____

Witness Signature

_____

Physician/Clinician Signature