# Self Discharge Against Medical Advice and Refusal of Treatment

Patient ID Sticker or write patient's name, address and CHI

**Hospital No** ……

**Consultant** ……

**Ward** ……

**Hospital** ……

**Assessment of the Patient's Ability to Self Discharge/Refusal of Treatment (All criteria must be fulfilled for the patient to be deemed capable)**

1. Does the patient UNDERSTAND the proposed medical treatment? (Its purpose, justification, benefits, risks and alternatives) Yes ☐ No ☐
2. Does the patient understand the RISK ASSOCIATED with not receiving the treatment? (For example risks that is very specific to them at this time) Yes ☐ No ☐
3. Is the patient able to retain the information for long enough to make an informed decision? Yes ☐ No ☐
4. Is the patient able to make a free choice without coercion or duress? Yes ☐ No ☐
5. Is the patient able to communicate their decision? (this may include the use of an interpreter) Yes ☐ No ☐

**NB – IF YOU ARE CONCERNED ABOUT THE INDIVIDUAL'S CAPACITY OR RISK POSED BY SELF DISCHARGE, DISCUSS WITH SENIOR STAFF AND CONSIDER REFERRAL TO LIAISON PSYCHIATRY FOR FORMAL ASSESSMENT**

**Assessment of the Patient's Medical Risk**

Indicate below the working diagnosis or presenting complaint

……

……

Proposed treatment

……

……

List below the risks of self discharge and refusal of treatment explained to the patient and fully document in the casenote

……

……

**Outcome:**

- Advised of symptoms to be aware of and when to seek medical attention Yes ☐ No ☐
- Advised patient s/he can return at any time for reassessment Yes ☐ No ☐
- Discharge against advice leaflet given Yes ☐ No ☐
- Patient self discharged without waiting for medical review Yes ☐ No ☐

Follow-up arrangements and other agencies informed (e.g. Social Services, GP, Prison Health Care Staff, Police, Next of Kin) please detail below:

……

……

Essential medication supplied to patient (should not exceed 48 hours supply)

……

……

**I the undersigned am taking my own discharge against medical advice. The risks of self discharge have been explained to me.**

**Patient's Name**..... **Signature**..... **Date** ……

**Doctor's Name**..... **Signature**..... **Date** ……

**Witness's Name**..... **Signature**..... **Date** ……

**Tick if information has been provided by interpreter** ☐ **Name of interpreter** ……

**PLEASE FILE IN PAITENTS MEDICAL RECORDS AND COMPLETE AN IR1 FORM**