بیمارستان کارمانیا
KARMANIA HOSPITAL

Discharge by personal consent

Unit Number			National ID Number
Family name:	Name	Ward:	Attending physician:
Date of admission:	Date of birth:	Room: Bed:	Father's name:

This section should be completed by the physician

Brief report about the disease

.....

.....

.....

The treatment that the patient refuses to accept

.....

.....

Consequences of not accepting diagnostic therapy

.....

.....

I am doctor.....the above-mentioned patient's physician regarding the diagnostic and therapeutic measures.....which is performed in order to treat the disease.....I have given the most important complications and the possible consequences of not accepting the following to ....., the recipient of the service / guardian / legal representative who has the legal authority to grant or not to grant the consent of the informed consent and the capacity of decision making in health matters

Physician seal and signature	Date and time:

In cases of dissatisfaction with the continuation of the treatment process and the request for discharge, with the personal consent of this part, the patient / legal representative of the patient, this part should be completed.

I'm ..... (patient/parent or legal representative of the patient) child of ..... holding the national ID card number ..... and birth certificate number..... issued from .....born in (fill in your birth place).....on.....(fill in your date of birth), has the necessary knowledge of the disease, the required treatment measures, and the consequences of each, as well as its alternative methods, especially the risks and complications of not accepting the treatment and the resulting risks. I'm refusing at my own insistence and without the authority of and against the advice of my attending physician, request to leave against medical advice. The medical risks/ benefits have been explained to me by a member of the medical staff and I understand the risks. Therefore, I hereby release the medical center, its administration, personnel, and my attending and/or resident physician from any responsibility for all consequences, which may result by my leaving under these circumstances.

Patient's (legal protector of patient's) signature and fingerprint	Date and time of obtaining consent:

This section is completed by witnesses

Name and family name: father's name: born on…… National ID Card/ birth certificate number……..the relationship with the patient ……. Telephone number ……	
Seal and signature of the first witness	Date and time:
Name and family name: father's name: born on…… National ID Card/ birth certificate number……..the relationship with the patient ……. Telephone number ……	
Seal and signature of the second witness ……..	Date and time:

This section should be completed by the hospital forensic specialist at the discretion of the treating physician

1. Identity documents of the recipient of the service …… legal representative of the recipient of the service are in accordance with the information entered in the patient's file. No patient identification documents were provided
2. The service recipient.....the guardian / legal representative of the service recipient, Mr. / Ms..... has the competence and legal ability to grant or not to grant the consent and the treatment letter and the decision-making capacity in the explained medical affairs.
3. The service recipient understands all the risks and consequences of not accepting treatment and discharge with personal consent. While insisting on the leave, all of the medical staff and hospital officials are not responsible for his request and possible consequences.

In an interview with the service recipient / parent / the legal representative of the service and the study of the clinical file, according to the forensic medicine expertise regarding the accuracy and validity of the law, the request for leave was included in the consultation form for operation.

Seal and signature of forensic expert	Date and time:

Please indicate the main reason for the request for discharge with the personal consent so that your comments can be used to improve hospital services.

Reasons related to the patient	The patient's economic situation
	Patient's personal problems
	Fear of treatment
	better Feeling
	Suggestions from patient acquaintances
Reasons related to treatment staff	Lack of trust in the quality of provided services
	Dissatisfaction with the behavior of hospital staff
	Lack of sufficient information to the patient
	Delay in performing diagnostic and therapeutic measures for various reasons
	Dissatisfaction with the progress of treatment
Hospital-related reasons	The hospital is situated for education
	dissatisfaction with the hospital's cleanliness
	dissatisfaction with the hospital's welfare facilities
	dissatisfaction with the food quality
	Dissatisfaction with hoteling of the hospital (ventilation, lighting, sound, etc.)

Others…….. Patient's/legal representative of the patient's signature: