FORM

LEAVE AGAINST MEDICAL ADVICE

LAMA (EMR/OPD) DAMA (IPD)


Patient Information:

Full Name: _____

Date of Birth: _____

UHID: _____

Contact Number: _____

Address: _____

Date of Admission: _____

Diagnosis: _____

Healthcare Facility Information:

Facility Name: _____

Treating Physician: _____

Department/Ward: _____

Reason for Leaving Against Medical Advice (LAMA):

( ) Personal reasons

( ) Financial constraints

( ) Dissatisfaction with treatment

( ) Wanting to seek alternative treatment

( ) Other (please specify):

_____

_____

_____

_____

_____

Patient Declaration

I, _____**[Patient's Name/ Guardian's name]**, /acknowledge that I have been fully informed about my current medical condition and the potential risks associated with leaving the healthcare facility against medical advice in the language of my understanding. I understand that:

1. My condition may worsen, and I may require urgent medical intervention.
2. The healthcare facility and treating physicians are not liable for any consequences resulting from my decision.
3. I will not hold the healthcare facility, physicians or any medical staff responsible, related to my decision to leave.
4. I have been advised of alternative treatment options and potential outcomes but choose to leave voluntarily.

Declaration:
I voluntarily request to leave the facility against medical advice, and I take full responsibility for my decision.

Signature:

Patient Name: _____

Patient/Guardian Signature: _____

Date & Time: _____

Witness Information:

Name of Witness: _____

Relationship to Patient: _____

Signature of Witness: _____

Date & Time: _____

Physician/Healthcare Provider Acknowledgment:
I have explained to the patient the medical risks associated with leaving against medical advice, and the patient has chosen to proceed.

Physician Name: _____

Physician Signature: _____

Date & Time: _____

This form is to be retained at the healthcare facility in the patient's medical records.

Patient Declaration

Nga, _____**[Kyrteng nongpang/ Nongap]**, nga pyn tikna ba nga lah sngewthuh ia ka jingbthah shaphang ka jingshitom jong nga, bad ruh ia ki jing ma ha kaba iadei bad ka jing bym kwah ban bteng ia ka jingsumar ha kane ka hospital.

Nga sngewthuh ba:

1. Ka jingshitom ka lah ban nang jur, bad ba nga lah ban donkam ia ka jingsumar ba mar mar.
2. Ka Hospital bad ki Doktor ba sumar ia nga, kin nym kit khlieh lada jia kano kano kaba sinew halor kane ka rai kaba nga shim.
3. Nga pyn tikna ban nym kynnoh ia ka hospital lane ia ki doctor bad ia kiwei kiba trei ha kane ka hospital halor kane ka rai kaba nga shim.
4. Nga lah ioh ki jingbthah ha kaba iadei bad ki lad jingsumar bapher bad ki jingmyntoi, hynrei nga kut jingmut ban mih noh na kane ka hospital.

Declaration:
Nga kut jingmut ban mih noh na kane ka hospital pyrshah ia ka jingbthah jong ki doktor, bad ban shim jingkitkhlieh hi ia kane ka rai jong nga.

Signature:

Patient Name: _____

Patient/Guardian Signature: _____

Date & Time: _____

Witness Information:

Name of Witness: _____

Relationship to Patient: _____

Signature of Witness: _____

Date & Time: _____

Physician/Healthcare Provider Acknowledgment:
I have explained to the patient the medical risks associated with leaving against medical advice, and the patient has chosen to proceed.

Physician Name: _____

Physician Signature: _____

Date & Time: _____

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SAGIPARANGNI UI·E RA·ANI

Anga _____(sagipa mande ni bimung) antangni saani gimin u.ie, ia sanram biaponi,sanenggipa Doctor aro nurse rangni aganako manigija dakara mai asel onggen jekai

1) Angni saani biljimbatnaba donga aro ranggitik sananirangko dakna nangnaba donga.
2) Sanengiparangna aro hospitalo kam ka.giparangna,angni kamrangchi mamung namgija asel ongjachina.
3) Angni daka kamrangchi antangko sanengiparangna mamung matnanganiko rabajawa.
4) Angna dingtang sanani cholrangkoba masiataha indiba uarangko dakgija, sanram biaponi reongkatna gita miksongaha.

Ia sanram biaponi reongkatna gita,anga antangan darangni kattako manigija dakna gita chanchiaha.

Anga (sagipa mandena) sananiko ragija repilangani mai nengnikaniko rabaagen,uko tale masiaha indiba anga uarangko knaachakgija ,sanram biaponi reongkatna gita miksongaha.

Signature:

Patient Name: _____

Patient/Guardian Signature: _____

Date & Time: _____

Witness Information:

Name of Witness: _____

Relationship to Patient: _____

Signature of Witness: _____

Date & Time: _____

Physician/Healthcare Provider Acknowledgment:
I have explained to the patient the medical risks associated with leaving against medical advice, and the patient has chosen to proceed.

Physician Name: _____

Physician Signature: _____

Date & Time: _____

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