Against Medical Advice Form

Nursing Home

Resident Information:

- **Full Name: _____**
- **Date of Birth: _____**
- **Room Number/Unit: _____**

Facility Information:

- **Facility Name: _____**
- **Address: _____**

Description of Advised Care:

- **Description of Medical Advice or Recommended Treatment:**

  _____

  _____

Reason for Declining Care:

- **Please provide your reason for refusing the advised care:**

  _____

  _____

Acknowledgment of Risks:

I acknowledge that I have been informed of the potential risks associated with refusing the recommended treatment, which may include but are not limited to:

☐ **Worsening of the medical condition**

☐ **Risk of injury or accidents**

☐ **Increased dependency on caregivers**

☐ **Other:**

_____

Declaration:

I release the nursing facility and its staff from any liability resulting from my decision to decline care.

Resident Signature: _____ Date: _____

Guardian/Power of Attorney Name (if applicable): _____

Guardian/Power of Attorney Signature: _____