AGAINST MEDICAL ADVICE (AMA FORM)

This is to certify that I,			
a patient at			
		MEDICAL RISKS	
		Death	Additional pain and/or suffering
		Risks to unborn fetus	Permanent disability/disfigurement
Other:			
MEDICAL BENEFITS			
History/physical examination, fas indicatedRadiological imaging such as:CAT scanX-rays ul	further additional testing and treatment trasound (sonogram)		
Laboratory testing Potentional admission and/or follow-up Medications as indicated for infection, pain, blood pressure, etc Other:			
Please return at any time for further t	testing or treatment		
Patient Signature	Date		
Physician Signature	Date		
Witness	Date		