caevIs gam siCcdan>d meDIkl AeND rIscR seN3r s>cailt

7@@aa haeiSp3l – vhera

Baearsd –sIglav raeD, mu baersd + Aa`>d

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Dama peseN3 ma3enu faemR

Kes n>br :- \_\_\_\_\_\_\_\_\_\_ tarIq :- \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Samy :- \_\_\_\_\_ ddIRnu nam:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hu> nIce shI krnar nam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ swanta puvRk j`avu 0u> ke mne mara ddIRnI g>wIrta ivxe ja` krel 0e. tem 0ta> hu> marI mr+4I DaRk3rnI slah ivru@2 mara ddIRne marI jvabdarI4I haeiSp3lma>4I 2re l[ ja]> 0u>. haeiSp3l 0aeDya bad mara pesN3ne ka>[p` 4ay tena ma3e Daek3r ke haeiSp3l S3af jvabdar rhexe nhI.

ddIRna sganI shI / A>gu#anu> inxan : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

sgp` : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

faen n> : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

sa9I nI shI : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHOVIS GAM SACHINAND MEDICAL & RESEARCH CENTER

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FORM FOR DISCHARGE AGAINST MEDICAL ADVICE

CASE NO:- \_\_\_\_\_\_\_\_\_ DATE :- \_\_\_\_\_\_\_\_\_\_\_\_\_\_

TIME :- \_\_\_\_\_\_ PATIENTNAME:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, undersigned Mr./Mrs./Ms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sincerely declare that I have been informed about my patient’s situation and seriousness of his/her health by hospital authority. Yet I want to discharge my patient from hospital with my prior permission. So if ant criticalness occur to my patient offer relieving hospital than doctor or hospital staff shall not be responsible in any cases.

Patient Relative’s Sign/Thumb Impression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_