LETTER OF ACKNOWLEDGEMENT FOR AGAINST MEDICAL ADVICE

Myself _ NRIC/Passport No _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ , am the *self/parents/spouse/children/caretaker/relative for this patient, _ NRIC/Passport No _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ , hereby refuses the treatment/procedure _ offered to me/this patient. I acknowledge the fact that I was informed of the detailed information regarding the above treatment/procedure including its importance and benefits.

I was also informed and understood the risks involved if this treatment/procedure is not done. I acknowledge that this decision is of my own will. I will take full responsibility for any possible outcome from my own decision and action.

I hereby promise that I will take no law action against the hospital or any other related parties shall any unwanted event occurs due to this decision and action of mine.

Signature : _ _ _ _ _ _ _ _ _ _ _ _ _
*(*self/parents/spouse/children/caretaker/relative)*
please state relationship : _ _ _ _ _ _ _ _ _ _ _ _ _
Address : _ _ _ _ _ _ _ _ _ _ _ _ _
_ _ _ _ _ _ _ _ _ _ _ _ _
Contact No : _ _ _ _ _ _ _ _ _ _ _ _ _
Date : _ _ _ _ _ _ _ _ _ _ _ _ _

Translator's Signature : _ _ _ _ _ _ _ _ _ _ _ _ _
(if applicable)
Translator's Name : _ _ _ _ _ _ _ _ _ _ _ _ _
NRIC/Passport No : _ _ _ _ _ _ _ _ _ _ _ _ _
Date : _ _ _ _ _ _ _ _ _ _ _ _ _
Language used : _ _ _ _ _ _ _ _ _ _ _ _ _

Doctor's Signature : _ _ _ _ _ _ _ _ _ _ _ _ _
Doctor's Name : _ _ _ _ _ _ _ _ _ _ _ _ _
MPM No : _ _ _ _ _ _ _ _ _ _ _ _ _
Date : _ _ _ _ _ _ _ _ _ _ _ _ _
Doctor's Stamp : _ _ _ _ _ _ _ _ _ _ _ _ _

Witness' Signature : _ _ _ _ _ _ _ _ _ _ _ _ _
Witness' Name : _ _ _ _ _ _ _ _ _ _ _ _ _
NRIC/Passport No : _ _ _ _ _ _ _ _ _ _ _ _ _
Position : _ _ _ _ _ _ _ _ _ _ _ _ _
Date : _ _ _ _ _ _ _ _ _ _ _ _ _