File within 3rd spine

NHS number: ______________________
Name: ______________________
Address: ______________________
____
Date of birth: ______________________
CR number: ______________________

Affix patient label

NHS

Royal Cornwall Hospitals
NHS Trust

Child Health - Leave without being seen (Discharge)

For the parent / guardian or young person that leaves without being seen by a medical practitioner

To be completed by the parent / guardian / young person prior to the patient being taken from this hospital.

Ward / Department:	Hospital:

Discharge information

I have chosen to discharge my child / myself from this hospital before being reviewed by the appropriate medical team. I have discussed my decision with a nurse / doctor and understand the consequences of my decision.

I have received support / advice and information about the condition for which I attended the hospital and understand this.

If my child becomes more unwell or if I am worried about them, I understand that I can change my mind at any time and return for treatment. I know I will be contacted in the next 24 hours to ensure my child is not at risk from further deterioration.

Parent / guardian signature:

Parent / guardian telephone number:

Parent / guardian print name:

Witness signature:

Witness print name:

Designation of witness:

Date:

This form when completed must be retained in the patient's medical record and a DATIX of the discharge without being seen event completed in every case by the relevant involved multi-disciplinary team member.

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