Patient Absence Request

_____ _____ UTMB Hospitals
(Name of Patient) (Room # and Unit)

I, the above named Patient, have my doctor's (or his or her designee's) approval for an absence from my hospital room on the date and for the time specified below:

Date: _____ Time: From _____ AM/PM To_____ AM/PM

By signing below, I acknowledge and understand that if I do not return to my hospital room at the time listed above, I may be discharged from the hospital and my room assigned to another patient on the waiting list for admission. Furthermore, I understand I am responsible for the room charge during my absence.

_____ _____
(Patient's Signature) Date

_____ _____
(Physician's Signature) Date

_____
(Legal Guardian's Signature – if applicable)

_____
(Relationship to Patient)

Exceptional Circumstances (if applicable):_____

_____

_____

This form must be completed by any patient who has received a doctor's order for the above absence from the hospital.

It is to be held at the Nursing Station during the absence and **SENT TO PATIENT FINANCE WHEN THE PATIENT RETURNS.**

if PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE IN DATE ,PT NAME AND UN# IN SPACE BELOW

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The University of Texas Medical Branch Hospitals