HOSPICE NORTH HASTINGS

END OF LIFE CARE PROGRAM

Admission Agreement

I, _____, request admission to the Hospice House North Hastings for the End-of-Life Care Program. This program is for patients in their last weeks of life and for their families. My primary physician has discussed my diagnosis and the expected course of my illness with me, to my satisfaction.

I understand that hospice care is aimed at controlling symptoms related to my illness and not at curing my illness, and that the goals and interventions employed by the Hospice do not include extra-ordinary measures, including cardiopulmonary resuscitation (CPR). Hospice recognizes that palliative care is directed toward improving quality of life and seeks neither to hasten nor postpone death.

I understand that I have the right to participate in developing my plan of care, and if I wish, to include my family. I also understand that I have the responsibility to provide accurate information, which may be useful to the Hospice in delivering appropriate care.

I understand that the services provided in the End-of-Life Care Program at the Hospice House for North Hastings include on site volunteers to assist myself and my family with activities of daily living, to provide emotional support and to perform activities to maintain the Hospice House as a clean and safe environment.

I understand that the professional nursing care and personal support care will be provided by Hospice North Hastings.

I understand that medical care will be provided by my own primary physician.

I understand that my own spiritual advisor will be welcome at the Hospice House and will participate in my care as I desire.

I give consent and approval for documentation to be kept by the Hospice North Hastings House, regarding the care provided to me while a patient in the End-of-Life Care Program. I understand that there will be sharing of information between the Volunteers and Staff of Hospice. I give consent to allow Hospice staff and volunteers to pick up medications from the pharmacy on my behalf.

I understand that it is my responsibility to appoint Powers of Attorney or Substitute Decision Maker, before admission to the Hospice North Hastings, to handle my medical and legal affairs.

I understand that the Hospice House North Hastings is a nonsmoking facility.

I understand that alcohol is allowed on the premises under Hospice supervision.

I understand that Hospice North Hastings will not be responsible for lost or missing money or valuables.

27 Bridge Street East, PO Box 875
Bancroft, ON K0L 1C0

(P) 613-332-8014 (F)613-332-8017
(E) info@hospicenorthhastings.com

I understand that I may voice my concerns regarding care and /or other services provided at the Hospice House North Hastings, either in writing or verbally to the Director of Hospice Services without fear of reprisal.

I understand that I have the right to withdraw from the End-of-Life Care Program at the Hospice House North Hastings at any time.

I understand that the Hospice has the right to maintain a therapeutic environment and my failure to comply with its policies may result in my discharge.

I understand that if my condition improves to a point where the Hospice may no longer be the best place of care for me (i.e.: my PPS is greater than 30%) that the Director of Patient Services &/or Director of Hospice Services will discuss with me and my family the possibility of moving to a more appropriate place of care.

I understand that for safety measures there is a monitor with live video surveillance utilized only by members of my care team to monitor me during my stay. The monitor ensures that members of the health care team are aware of my safety when they are not in the room with me. Anyone using the monitor has signed a privacy agreement and is bound by confidentiality.

I understand that if my care should require more than Hospice North Hastings is able to provide that I may be transferred to the local hospital.

_____ OR _____

Signature of Patient | Signature of Power of Attorney

_____ _____

Witness | Date

I,_____(POA), am aware that Hospice North Hastings will retain my contact information for the purpose of connection to Grief and Bereavement Services provided by Hospice North Hastings.

Mailing Address: _____ Phone Number: _____

_____

_____ _____

Signature of Power of Attorney | Date

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