



## **Service Agreement**

I request admission to Hospice North Hastings for hospice care. 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 by Hospice North Hastings include staff to assist myself and my family with activities of daily living and to provide emotional support.

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 or a local physician.

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

I give consent and approval for documentation to be kept by Hospice North Hastings, regarding the care provided to me while I am a client. I understand that there will be sharing of information between the care team. I give consent to allow Hospice staff 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 Residential Hospice 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.



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

I understand that I have the right to withdraw from services 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 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 (Residential Hospice only) 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

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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