THE HOSPICE HOUSE FOR NORTH HASTINGS

END OF LIFE CARE PROGRAM

Admission Agreement

I, _____, request admission to the Hospice House for 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 as a clean and safe environment.

I understand that the professional nursing care will be provided by through the SE Home & Community Care Access Centre. Personal Care needs will be addressed by Personal Support Workers who are also supplied through the SECCAC.

I understand that medical care will be provided by my own primary physician and that if I do not have a physician one of the Palliative Doctors from our community will be asked to take me on as a patient.

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

I give consent and approval for documentation to be kept by the Hospice, 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 and the staff and services provided by the CCAC.

I understand that it is my responsibility to appoint Powers of Attorney, before admission to the Hospice, to handle my medical and legal affairs.

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 the Hospice House for North Hastings, either in writing or verbally to the Client Care Coordinator without fear of reprisal.

I understand that I have the right to withdraw from the End of Life Care Program at the Hospice House for 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 (ie: my PPS is greater than 30%) that the Client Care Coordinator will discuss with me and my family the possibility of moving to a more appropriate place of care.

I understand that if my care should require the 24 hour services of Registered Nurses that I may be transferred to the local hospital.

I understand that The Hospice House for North Hastings is 100% community funded and I am prepared to support this service by naming Hospice North Hastings and only Hospice North Hastings,. in Lieu of Flowers, at my funeral.

_____ OR _____

Signature of Patient | Signature of Power of Attorney

_____ _____

Witness | Date

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