INFORMED CONSENT FOR CARE

PROVIDENCE
Hospice of Seattle

Patient Name: _____ DOB: _____ MRN: _____

Plan of Care:

I understand that hospice care is not curative in its goals and techniques. I understand that the focus of hospice care is to provide relief of symptoms such as pain, nausea and/or anxiety which are related to the hospice diagnosis for which I am being admitted. All treatments will be discussed with my Hospice team, myself and my family to assess the goals of treatment, coverage of treatment and benefits and risks of treatment.

I understand the Hospice program is composed of services delivered in my residence by a team of Hospice professionals and volunteers. These services are available on an intermittent basis, as needed twenty-four hours a day, seven days a week. Services may include nursing, physician care, medical/social, counseling, aide and therapy.

I understand that my care is based on a plan developed by myself, my family and the hospice team. My questions have been answered to my satisfaction. I understand that if the plan of care changes these changes will be discussed with me.

I have received:

[ ] Notice of Privacy Practice

[ ] A copy of the Patient and Family Guide to Hospice Care

[ ] Information about Living Wills and Durable Powers of Attorney for Healthcare

[ ] A copy of Client/Family Rights and Responsibilities

[ ] A copy of the Grievance process for handling concerns about my care

I have a Living Will: [ ] Yes [ ] No

I have a Durable Power of Attorney for Healthcare (DPOA): [ ] Yes [ ] No

If yes, the name of my DPOA is _____

By signing this, I acknowledge that I consent to care from Providence Hospice of Seattle and give the Hospice team permission to administer treatment to me under the direction of my personal physician.

Patient Signature: _____ Date: _____

DPOA Signature: _____ Date: _____

Witness Signature: _____ Date: _____