THE HEART OF HASTINGS HOSPICE

END OF LIFE CARE PROGRAM

Admission Agreement and Consent to Care

I, _____, request admission to The Heart of Hastings Hospice house
Resident/substitute decision maker

for the End of Life Care Program. This program is for clients in their last stage 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 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.

DNR in place □ Yes □ No

Hospice complies with the Ontario Personal Health Information Protection legislation. For the purposes of care planning and providing services, the hospice may collect and share my information, including personal health information, in a confidential manner. I understand that I have the right to participate in medical direction of care, and if I wish, to include my family. I have the responsibility to provide accurate information, and may request access to the information and the privacy policy.

I understand that medical care will be provided by my own primary physician and that if I do not have a physician or a physician is not available to me, that a physician will be available for end of life treatment and care.

I understand that the professional clinical and personal care services provided in the End of Life Care Program at The Heart of Hastings Hospice House include a team of on-site nurses and personal support workers as well as volunteers. This interdisciplinary care team's goal is to assist my family and I with activities of daily living, to provide comfort measures, to provide emotional support and to perform activities to maintain the Hospice House as a clean and safe environment.

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, regarding the care provided to me while a patient in the End of Life Care Program. I understand the need and consent to the release of information between the Volunteers and Staff of the Heart of Hastings Hospice and Home Community Care Coordinator. 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 Heart of Hastings Hospice, to handle my medical and legal affairs.

I understand that The Heart of Hastings Hospice 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 Heart of Hastings Hospice House, either in writing or verbally to the Residential Manager without fear of reprisal.

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

I understand that The Heart of Hastings Hospice has the right to maintain a therapeutic environment and failure to comply by myself or family/visitors with its policies may result in my discharge. There are designated areas where smoking is permitted. Alcohol is allowed on the premises under the Heart of Hastings Hospice supervision. I also understand that marijuana can be used in the oil or edible format through oral administration. For medical or recreational use the marijuana must be self-administered or administered with assistance from my family.

I understand that if my condition improves to a point where The Heart of Hastings Hospice may no longer be the best place of care for me, the Executive Director will discuss with my family and I the possibility of moving to a more appropriate place of care.

I understand that there is no charge for services provided by The Heart of Hastings Hospice but we do ask that you name The Heart of Hastings Hospice as the recipient of memorial donations. This will help keep this service available for others.

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.

_____ _____

Date Client Signature/ Substitute Decision Maker

_____

Print Name: Client/Substitute Decision Maker

_____

Signature of Witness