MinnesotaHospice
THE GOLD STANDARD of Care

Patient Consent for Care

Name: _____ **Admission Date:** _____

INFORMED CONSENT AND AGREEMENT TO THE FOLLOWING

- I request admission to Minnesota Hospice.
- I have a life-limiting illness and understand that hospice's goal is palliative and not curative.
- A representative has explained the type of care and services that Minnesota Hospice may provide during the course of my illness.
- I understand and was given the opportunity to ask questions.
- I consent to care and treatment that may be performed as part of my care plan and that I, along with my family, attending physician, and Minnesota Hospice interdisciplinary team will develop my plan of care.
- I will ask family members or significant others to respect the choice of Minnesota Hospice and to fulfill the role of primary caregiver.

RELATIONSHIP BETWEEN MINNESOTA HOSPICE AND PATIENT/FAMILY

- Minnesota Hospice promotes the comfort and dignity of patients and addresses the physical, emotional, social and spiritual needs of the patient and family through an interdisciplinary team approach.
- Patient care is provided by professionals and volunteers both on a scheduled basis and as needed 24 hours a day, seven days a week, 365 days a year.
- The Minnesota Hospice team does not take the place of the family in caring for the patient.
- The Minnesota Hospice Medical Director does not take the place of the attending physician but will provide consultation in symptom control as a member of the interdisciplinary team
- Notations will be made on Minnesota Hospice medical records including care plans concerning the medical, nursing, psychosocial, spiritual and personal information.

ACKNOWLEDGEMENT OF RECEIPT AND/OR UNDERSTANDING OF THE FOLLOWING

- Notice of Privacy Practices
- Understanding Advance Directives
- Patient and Family Rights and Responsibilities
- State of Minnesota Hospice Bill of Rights

The above information can also be found @ www.minnesotahospice.com

ADVANCE DIRECTIVES

- I have been given written information about my right to accept or refuse medical treatment
- I have been given state specific Advance Directive information
- I understand that I am not required to have an Advanced Directive in order to receive hospice care
- I have executed an Advance Directive. My healthcare POA/DPOA is: _____
- My healthcare POA/DPOA phone number is: _____
- I **have not** executed an Advance Directive

I attest that I have been advised of my rights and responsibilities. All services have been explained to me and I have had ample opportunity to ask questions.

Patient Signature _____ Date _____

Authorized Representative (Print name) _____ Relationship _____

Signature of Authorized Representative _____ Date _____

Signature of Minnesota Hospice Representative_____ Date _____