North Shore Hospice Admission Agreement

Client Name: _____ Date of Birth (dd/mm/yy): _____

PHN: _____ PARIS number: _____

Designated Decision Maker Name and Contact Details: _____

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I agree to be admitted to the North Shore Hospice:

- √ I choose Hospice as preferred place of death; **or**
- √ I require tertiary Palliative Care that cannot be provided at home, such as malignant wound or complex pain management.

I have been fully informed and I accept Hospice Philosophy including all the following:

1) North Shore Hospice is a specialized form of palliative care explicitly for terminally ill patients who are facing imminent death
2) Hospice Care accepts death as inevitable, respects the patient's right to die with grace and dignity and seeks to neither hasten nor prolong a patient's dying process
3) The patient and/or family have a clear understanding of diagnosis, prognosis, and that the client is in the actively dying phase of a terminal illness and no further treatment will reverse this.
4) Hospice care aims to provide maximum comfort and symptom control and therefore clear recognition that no further life prolonging treatment will be beneficial; including Intravenous therapy, investigations, dialysis, insertion of nasogastric tubes, subcutaneous anticoagulants, Total Parenteral Nutrition.
5) Medical interventions in Hospice will be aimed at comfort and symptom relief only and no therapy will be provided or supported that aims to prolong life.

My care will be planned in partnership with me and /or my family, my family physician, North Shore Hospice Staff and the North Shore Palliative Care Program Consultation Team.

I understand that if my condition stabilizes or improves, arrangements will be made for discharge home or to a long term care facility.

I allow that, during the course of my care, the information contained in my health record (paper or electronic) may be shared with authorized caregivers, and to such others as may be permitted by the Freedom of Information and Protection of Privacy Act.

I recognize that, while every effort is made to protect the possessions of each resident, North Shore Hospice cannot accept responsibility for damage or loss of personal effects. I agree to make arrangements for all my personal effects (including furniture, pictures) to be removed within 48 hrs of discharge, or these items will be donated to a local charity.

I have read and agree to accept the policies, procedures and directions outlined in the North Shore Hospice brochure.

I understand that any prescription costs not covered by Plan P will be billed directly to me (or my representative) from _____Pharmacy.

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Signature of Resident / Designated Decision Maker Printed Name of Resident

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Signature of Witness Printed Name of Witness