Hospice
ADMISSION AGREEMENT

1. I understand that hospice is for patients who are in the last weeks or months of their life and that my physician has talked to me about my illness and what to expect.

2. I understand that hospice focuses on quality of life by providing a home−like setting and professional care for patients and families. I understand that tests and treatments like reqular blood tests, x−rays, chemotherapy, intravenous (IV) treatments and blood products are not provided in hospice. I understand that life−prolonging measures, like CPR or emergency transfers for resuscitation, are not provided in hospice.

3. I can expect that my physical, emotional and spiritual well−being will be the hospice care team’ s priority. The hospice care team may also work with Continuing Care, my family physician, the local palliative care team, and other healthcare professionals as needed.

4. So that the hospice can provide the best care possible, I give permission for my personal health information to be shared within the hospice care team and authorize the hospice to share my health information with other healthcare providers and learners, when needed. If I no longer wish for my personal health information to be shared, I must tell the hospice in writing.

5. I understand that a team of registered nurses, licenced practical nurses, care team assistants, and physicians care for patients 24 hours a day, 7 days a week at the hospice. Other roles on our team include social work, occupational therapy, and spiritual care.

6. I understand that volunteers are an important part of the hospice care team and will regularly help with my non−medical care and support.

7. I understand that hospice care can improve my condition such that I may no longer need ongoing care at the hospice. If the hospice care team determines that I can be discharged safely to home, or transfer to another care setting like a long term care facility, I am not able to refuse.

8. I understand that I can be moved to a different room for hospice to meet my specific needs or the needs of other patients.

9. I understand that medical care benefits covered under the Nova Scotia Health Insurance Program will continue while I am a patient at the hospice.

10. I understand that my medications will be provided by the hospice’s partner pharmacy. Although the pharmacy will try to make sure my medications are covered through provincial or private programs, I understand that if this is not possible, I may be responsible for some costs.

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11. I will not hold the hospice responsible for any loss of money, valuables or personal effects that are kept in the hospice. I will not hold the hospice responsible for any injuries resulting from the care provided to me other than by employees or agents of the hospice.

12. I understand that my delegate or substitute decision maker (SDM) will make health and personal care decisions for me if I am not able to communicate about my care.

13. I can decide to change my care plan at any time. However, if I choose to leave the hospice for treatment or medical investigations at a hospital, I understand that my place at the hospice may no longer be held for me.

❑ **Patient:**

Print Name: ____________________

Signature: ____________________

Date (YYYY/MON/DD): ____________________

❑ **Delegate / Substitute Decision Maker** is to sign Admission Agreement if the patient lacks capacity to direct their care:

Print Name: ____________________

Signature: ____________________

Relationship to Patient: ____________________

Date (YYYY/MON/DD): ____________________

❑ **Healthcare Professional** – I have reviewed the form with my patient:

Print Name: ____________________

Professional Designation: ____________________

Signature: ____________________

Date (YYYY/MON/DD): ____________________