Presentation Centre | 3 St. Catherine Street | Grand Falls-Windsor, NL
A2A 1V7 | t: 709.489.1222 | w: lionelkellandhospice.ca

FIRST NAME: _____ **LAST NAME:** _____

DOB (D/M/Y): _____ **MCP**: _____

LIONEL KELLAND HOSPICE ADMISSION AGREEMENT

1. I understand that hospice is for residents who are in the last weeks to months of their life and that my primary health care provider 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 residents and families. I understand that tests and treatments like regular 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 my primary care provider, the local palliative care team, and other healthcare professionals as needed.

4. I give permission for my personal health information to be share within the hospice care team and authorize the hospice to share my health information with other health care providers and learners, when needed, to provide the best possible care. 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, licensed practical nurses, personal care assistants, and physicians care for residents 24 hours a day, 7 days a week at the hospice. Other roles on our team include Social Work and Programs Lead and spiritual care.

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

7. I understand that if my condition improves and the hospice care team determines that I can be discharged safely to home or transferred to another care setting such a long-term care facility, a transfer or discharge plan will be discussed with me or my delegate/substitute decision maker. If I refuse the transfer or discharge, I understand that additional charges may apply in accordance with NL Health Services or hospice policy.

8. I understand that where it is appropriate to meet my health or personal needs, or the needs of other residents, I can be moved to a different part of the hospice or another facility where necessary care could be provided.

9. I understand that medical care benefits covered under the publicly funded health care program will continue while I am a resident at the hospice.

LIONEL KELLAND HOSPICE
CARE • RESPECT • DIGNITY

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10. I understand that my medications will be provided by the hospice's preferred pharmacy.

11. I will not hold the hospice responsible for any loss of money, valuables, or personal effects that are kept in the hospice. There will be a locked drawer in each room for this purpose.

12. I will not hold the hospice responsible for any injuries resulting from the care provided by other individuals (loved ones/families) that are not employees or agents of the hospice.

13. I understand that my delegate or substitute decision maker (SDM) will make health and personal care decisions for me if I no longer have the capacity to do so.

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

Resident

Print name: _____

Signature: _____ Date (DD/MM/YYYY): _____

OR

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

Print Name: _____

Signature: _____

Date (DD/MM/YYYY): _____

Healthcare Professional – I have reviewed the form with my resident:

Print Name: _____

Professional Designation: _____

Signature: _____ Date (DD/MM/YYYY): _____