

**GILCHRIST HOSPICE CARE**  
**CONSENT FOR CARE**

**Patient Name:** \_\_\_\_\_  
**Medical Record #** \_\_\_\_\_  
**Date of Admission:** \_\_\_\_\_

I choose to receive HOSPICE care from Gilchrist Hospice Care. I understand the following:

1. I will receive care from my primary physician or another appointed physician.
2. I understand the goal of hospice is to reduce symptoms and promote freedom from pain, discomfort, anxiety and all disturbing symptoms of my life limiting illness. In addition, I understand that care is not intended to be curative or to alleviate the illness, but to the extent possible, to reduce the discomfort of the symptom(s).
3. I understand the choices related to cardiac resuscitation as discussed with me by Gilchrist Hospice Center staff. I understand that Gilchrist Hospice Care will initiate basic resuscitation in the absence of my verbal or written advance directive. However, if basic CPR is initiated, staff will call 911 for transport to an acute care facility.
4. I understand that the Gilchrist Hospice Care team of Physician, nurse(s), social worker, assistant-patient care / home health aide, volunteer, bereavement counselor and chaplain will provide physical, emotional, social and spiritual support to me, my primary care giver, and any significant others involved in my life within the limits of Gilchrist Hospice Care's resources.
5. I understand that if I am to receive the full benefits of hospice care, it is important to make my needs known to the Gilchrist Hospice Care staff. I and/or my Primary Caregiver will actively participate in plans for my care.
6. In the event that I elect to move my residence within the Gilchrist Hospice Care service area, I understand that I can continue to receive hospice care from Gilchrist Hospice Care.
7. I understand that \_\_\_\_\_ has committed to be my Primary Caregiver. This  
(PCG name)  
means he/she will be the person mainly responsible for directing my care.
- I, \_\_\_\_\_, have committed to be the Primary Caregiver. With the support of the  
(Print PCG name)  
Gilchrist Hospice Center I will direct the care for \_\_\_\_\_.  
(Pt. Name)
8. I do \_\_\_ / I do not \_\_\_ give consent for fiscal intermediary review personnel to conduct home visits in order to review the hospice services to insure that quality care is being provided and that the services received are appropriate.
9. I understand that the focus of hospice care is in the home. Instruction on care will be provided to my caregiver and myself by Gilchrist Hospice Care. Care provided in my home will be by scheduled appointments. In addition, a hospice nurse is available 24 hour a day, 7 days a week. The hospice nurse will offer assistance either by phone or, when appropriate, through a visit. The Gilchrist Hospice Care phone number is (443) 849-8200 (TTY 1-800-735-2258).
10. I acknowledge that I have been given ample opportunity to ask any questions that I have concerning Gilchrist Hospice Care's program of care. I have received a copy of the Patient Rights and Responsibilities document and have been given the opportunity to ask questions regarding the content.
11. My signature on this form acknowledges that I have received a copy of GBMC's/ Gilchrist Hospice Care's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Gilchrist Hospice Care and my rights with respect to my health information.

\_\_\_\_\_  
PATIENT SIGNATURE or PERSONAL REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRIMARY CAREGIVER SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
GILCHRIST HOSPICE CARE REPRESENTATIVE

\_\_\_\_\_  
DATE