HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

First follow these orders, then contact Physician / NP / PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: **M F**

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

ABBA Hospice, Inc. 20955 Pathfinder Rd. Suite 332, Diamond Bar, CA 91765

INFORMED CONSENT AND TREATMENT AUTHORIZATION

This agreement is entered into by and between **ABBA Hospice, Inc.** (hereinafter called Agency) and _____ (hereinafter called Patient). This agreement is entered into pursuant to a desire by Patient to obtain Hospice services. I request admission to Hospice and understand and agree to the following conditions:

1. I understand that the Hospice program is palliative, not curative, in the goals and treatments. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual needs and the emotional stress which may accompany a life-threatening illness.
2. I understand I am encouraged to participate in the development and implementation of the approved plan of care and that Hospice services are not intended to take the place of care by family members or others who are important to the patient, but rather to support them in the care of the patient. With the help of hospice, the person designated the "caregiver" will provide around-the-clock care to the patient in their place of residence. If twenty-four-hour care is not available, the caregiver will arrange for another to provide it. The caregiver will also participate in decisions about the care provided to the patient. The Hospice Interdisciplinary Team supplements rather than replaces care provided by the family or Care Center Staff.
3. I accept the conditions of Hospice ad described, understanding that I may choose not to remain in the program and that Hospice may discharge me from the program if hospice care is no longer appropriate. This means there will be no further liability to me or to Hospice. I understand, however, that I may request to be readmitted at a later date. I have been able to discuss the above conditions with a member of the Hospice staff and have had my questions answered to my satisfaction.

TREATMENT AUTHORIZATION: The undersigned Patient or Patient's legally authorized representative hereby consents to any and all examinations and treatments prescribed by the Patient's physician (or hospice physician) rendered by the Agency's licensed nurses, physical therapists, occupational therapists, speech therapists, registered dietitians, social workers, spiritual counselors, home health aides and volunteers.

FINANCIAL AGREEMENT:

In consideration of the mutual promises and obligations related to treatment rendered to Patient by Agency, it is agreed as follows:

1. ***Payment Responsibility:*** It is understood that for Hospice patients, the agency assumes financial responsibility for medications and/or durable medical equipment and medical supplies related to the terminated illness, agency, in accordance with this agreement for the Patient and/or Patient's agent assumes financial responsibility for all other authorized charges. The agency in accordance with this agreement shall assist the Patient in obtaining financial assistance from third-party payers such a Medicare and private insurers.
2. ***Pharmacy Services:*** I acknowledge that I have the right to direct a pharmacist to dispense a prescription using the brand my physician prescribed instead of a generic drug product. I also understand that generic drug products generally cost less than brand name products, but the price differences vary from prescription to prescription. I hereby consent and agree that, if allowable under state law, any pharmacist who dispenses any of my prescription drugs may select a drug product that is generically equivalent to the brand prescribed by my physician, unless I submit to Hospice a written request for a brand name product.
3. ***Termination***: The agency may terminate services when in its sole medical judgment determines there is no longer any reasonable expectation that it can meet the Patient/family's needs.

MEDICARE / MEDICAL HOSPICE BENEFIT ELECTION

As a Medicare Part A or Medical beneficiary, I hereby elect **ABBA Hospice, Inc.** as my sole provider of hospice care
Effective _____
Date (mm/dd/yy)

I understand the hospice program to be palliative, not curative in its goal and treatment, which the program emphasizes the alleviation of physical symptoms including pain, and the identification and meeting of emotional and spiritual needs that the patient and family may experience related to the terminal illness.

PATIENT:_____MR#_____Initial_____
(Last) (First)

INFORMED CONSENT AND TREATMENT AUTHORIZATION

I understand that while this election is in force, Medicare/Medical will make payments for care related to this illness on to the physician designated below and to **ABBA Hospice, Inc.,** and that services related to this illness provided by hospitals, home health agencies, nursing homes, and any other company or agency will not be reimbursed by Medicare/Medical unless specifically ordered and authorized by Hospice. I understand the services not related to this illness will continue to be covered by Medicare/Medical along with hospice benefits.

HOSPICE SERVICES:

☐***Routine Home Care:*** I understand that hospice services are delivered primarily in the home (which may include a nursing home) provided by a team of hospice professionals, staff and volunteers. These services are available both on a scheduled basis and as needed. I understand that these services may include, as set forth in the hospice plan of care: nursing, physician care, social worker, spiritual, nutrition, bereavement counseling, home health aides, medical supplies, physical therapy, occupational therapy, speech-language therapy, and medications prescribed for relief of pain or discomfort.

☐***Inpatient Care/Inpatient Respite:*** I understand that inpatient hospice care and inpatient respite care are provided in an inpatient bed when it is deemed necessary by the hospice interdisciplinary team. I understand that hospice inpatient care is designed for short term stays with the goal of stabilizing the patient and family emotionally and physically, so the patient can return to home. I understand that inpatient respite care is designated to provide brief periods of respite for the family or primary care while the patient receives hospice care in an inpatient bed.

☐***Continuous Care:*** I understand that continuous care (1 minimum of 8 hours of care is a 24 hour period) may be provided in a patient's home when it is deemed necessary by the hospice interdisciplinary team. I understand that continuous care is designated for short-term periods to manage acute medical symptoms with the goal of stabilizing the patient.

I understand that under the Medicare/MediCal Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods and subsequent 60-day periods of unlimited duration. The Hospice Interdisciplinary Team evaluates recertification for continuation of hospice care at the end of each benefit period.

I understand that I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary group and documented on my plan of care.

I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to Hospice prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of the current election period.

I understand that once in each election period I may elect to receive services through a hospice program other than ABBA Hospice, Inc. such change shall not be considered a revocation of hospice services.

PATIENT:_____MR#_____Initial_____
(Last) (First)

ABBA Hospice, Inc. 20955 Pathfinder Rd. Suite 332, Diamond Bar, CA 91765

INFORMED CONSENT AND TREATMENT AUTHORIZATION

Patient Rights

As a Hospice patient, you have the right to:

1. Be informed of your rights verbally and in writing in a language and manner that you understand.
2. Make informed decisions regarding proposed and ongoing care and services.
3. Choose whether or not to participate in research, investigation or experimental studies, or clinical trials.
4. Have your communication needs met.
5. Have complaints heard, reviewed and if possible, resolved.
6. Confidentiality of information, privacy, and security.
7. Be fully informed, as evidenced by your written acknowledgment or by that of your appointed representative, of these rights and of all rules and regulations governing patient conduct, prior to or at the time of admission,
8. Be involved in the care planning process.
9. Be fully informed by a physician of your medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in your medical treatment.
10. Formulate advance directives.
11. Have an appropriate assessment & management of pain.
12. Keep and use personal clothing and possessions.
13. An environment that preserves dignity and contributes to a positive self-image. Unlimited contact with visitors and others.
14. Be fully informed, prior to or at the time of admission, of services available through Hospice, and related charges, including services not covered under Titles XVIII or XIX of the Social Security Act.
15. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
16. Be advised of what hospice services are to be rendered and by what discipline, e.g., registered nurse, counselor, chaplain, etc.
17. Be advised in advance of any change in treatment, care, or services.
18. Be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, expect in the case of transfer to another health facility, or as required by law or third-party payment contract.
19. Be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
20. Not be subjected to exploitation, verbal, sexual or physical abuse of any kind, and to be informed that corporal punishment is prohibited.
21. Be informed by the licensee of the provisions of the law regarding complaints, and procedures for registering complaints confidentially, including but not limited to, the address and telephone number of the local district office of the Dept. of Health Services.
22. Be informed of the provisions of the law pertaining to advance directives, including but not limited to living wills, power of attorney for health care withdrawal or withholding of treatment and/or life support.
23. Be assured the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.
24. Be informed of their rights in regards to beneficial relationship between the organization & referring parties.
25. Be informed of your right to choose your own Physician

Patient Responsibilities

As a Hospice patient, you have the responsibility to:

1. Remain under a doctor's care while receiving hospice services.
2. Inform the hospice of advance directives or any changes in advance directives, and provide the hospice with a copy.
3. Cooperate with your primary doctor, hospice staff and other caregivers by providing information, asking questions and following instructions.
4. Advise the hospice of any problems or dissatisfaction you have with the care provided.
5. Notify the hospice of address or telephone number changes or when you are unable to keep appointments.
6. Provide a safe home environment in which care can be given Conduct such that if the patient's or staff's welfare or safety is threatened, service may be terminated.
7. Obtain medications, supplies, and equipment ordered by your physician if they cannot be obtained or supplied by the hospice.
8. Treat hospice personnel with respect and consideration.
9. Sign the required consents and releases for insurance billing, and provide insurance and financial records as requested.
10. Accept for consequences for any refusal of treatment or choice of non-compliance.
11. Advise the agency of any problem or dissatisfaction with our care, without being subject to discrimination or reprisal. The Hospice shall investigate all grievances, document the existence of the complaint and findings. Findings will be communicated to the patient/family.

Procedures for Making complaints

If you have any complaints regarding the services you have received from Hospice, please contact the Administrator or Director of Patient Care Services at 909-468-2033

You may also direct your concerns to Joint Commission (JCAHO)
at 630-792-5800
Or
Department of Health Services Los Angeles County:
1-800-427-8700
The Department of Health Services office hours are:
Monday - Friday, 8 am - 5 pm except for holidays

You may write to them at the following address:
Department of Health Services (Los Angeles county)
313 N. Figueroa, Los Angeles, CA. 90012

All patients, regardless of race, religion, age, gender, sexual orientation, disability (mental or physical), color, ancestry, communicable disease, or place of national origin have the right to receive the same quality of care and to have access to the hospice resources they need to meet their health care needs.

_____
Patient's Name

_____ _____
Signature Date

ABBA Hospice, Inc. 20955 Pathfinder Rd. Suite 332, Diamond Bar, CA 91765

INFORMED CONSENT AND TREATMENT AUTHORIZATION

I have been providing the following information regarding advance directives:

☐ Informed of my rights to formulate an Advance Directive.

☐ I am not required to have an Advance Directive in order to receive medical treatment by any health care provider.

☐ The terms of any Advance Directive that I have executed will be followed by any health care provider and my caregivers to the extent permitted by law.

The patient has an Advance Directive:

☐ Power of Attorney for Health Care

☐ Living Will

☐ The patient does not have an Advance Directive.

Name and Address of Agent:

_____

_____

_____

Copy received: ☐ Yes ☐ No

RELEASE OF PATIENT RECORDS:

I understand that **ABBA Hospice, Inc.** may need to obtain medical records and related information form hospitals, nursing homes, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans, or others in order to assure continuity of care and proper reimbursement. I authorize the above persons and entities to release to **ABBA Hospice, Inc.,** and its representative's medical records and related information necessary to be helpful to the provision of hospice care. I also authorize **ABBA Hospice, Inc.,** and its representatives to release medical records and related information to others for the purposes of my health care, administration, and management of my health care (including utilization review), or processing and obtaining payment for services and supplies rendered to me. I understand and agree that this authorization specifically includes my permission and consent to release any information regarding a diagnosis of AIDS or the results of Human Immunodeficiency Virus (HIV) tests to the extent permitted by law. A photocopy of this authorization shall be as valid as the original.

RECEIPT OF INFORMATION:

Hospice services have been explained to me in a manner and language understood by me; I have been given the opportunity to ask any questions I have concerning the hospice program of care, and my questions have been answered to my satisfaction. I have been provided with the following materials:

☐ A copy of Patient's Rights

☐ Written materials explaining a patient's legal rights to accept or refuse medical treatments and to prepare an Advance Directive for health care.

RECEIPT OF ACKNOWLEDGEMENT:

I have received, acknowledged and agreed to the terms and conditions described in the following documents:

☐ Informed Consent and Treatment Authorization
☐ Medicare/Medical Hospice Benefit Election
☐ Notice of Privacy Practices
☐ Patient/Family Hospice Information
☐ Financial Agreement
☐ Advance Directives
☐ Compliant and Grievance Program

_____ _____

SIGNATURE OF PATIENT **DATE**

IF PATIENT UNABLE TO SIGN, STATE REASON: _____

_____ _____

SIGNATURE OF LEGALLY AUTHORIZED REPRESENTATIVE (If Applicable) **DATE**

_____

NAME AND ADDRESS OF LEGAL REPRESENTATIVE (PRINT) (If Applicable)

_____

HOSPICE CARE REPRESENTATIVE

PATIENT:_____MR#_____Initial_____

(LAST) (FIRST)

HOSPICE COVERAGE AND RIGHT TO REQUEST "PATIENT NOTIFICATION OF HOSPICE NON-COVERED ITEMS, SERVICES, AND DRUGS"

I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug copayment and inpatient respite care). I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists the items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. I acknowledge that I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determinations and I have been provided with the contact information for the BFCC-QIO that services my area: https://qioprogram.org/locate-your-qio or call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

☐ I elect to receive the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**
Initials_____ **Date**_____
(Hospice: Please provide the beneficiary with the addendum. Must be signed and dated accompanying the election statement.)

☐ I decline to receive the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**
Initials_____ **Date**_____

Note: *The hospice makes the decision as to whether or not conditions, items, services, and drugs are related for each patient. As the patient or representative, you should share this list and clinical explanation with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and elated conditions to assist in making treatment decisions.*

Right to Immediate Advocacy: *As a Medicare beneficiary, you have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to request for Immediate Advocacy if you (or your representative) disagree with the decision of the hospice agency on items not covered because the hospice has determined they are unrelated to your terminal illness and related conditions.*
BFCC-QIO Name: ***LIVANTA / https://livantaqio.com/en and BFCC-QIO Phone Number: 1-877-588-1123; 1-855-887-6668 (****TTY).*

The purpose of this addendum is to notify the beneficiary (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions. I acknowledge that I have been given a full explanation and have an understanding of the list of items, services and drugs not related to my terminal illness and related conditions not being covered by hospice. Signing this addendum (or its's updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily agreement with the hospice's determinations.

CONSENT TO PHOTOGRAPH

A patient, while under the care of Abba Hospice, Inc., depending on the overall condition of the patient, could develop some skin conditions like rashes, wounds (whether stage 1 or higher) etc. As a matter of Abba Hospice, Inc's policy, patients at the onset of these underlying condition, needs to be addressed immediately. Initially, our field nurses and/or other staff must report the situation as soon as possible, and at the same time, there might be a need to take photo/s of the skin condition for further consultation with Abba Hospice, Inc., Medical Director or a third party wound specialists. The photo could also be used during the discussion of patient's condition, status of the wounds and its progression, with the Inter Disciplinary Team (IDT) members.

In such a case, as a matter of policy, Abba Hospice, Inc., will see to it that the photo/s taken shall be done strictly with the following condition/s:

1. The focus of the photo shall be on the skin condition only.
2. That there will not be, at any point in time, in any frame of the photo, will it show the face of the patient, nor any private part of the patient that is not relevant and/or necessary in addressing the said skin condition.
3. That the said photo shall be used entirely for the purpose of developing a plan of care for the patient, specifically, in addressing the skin condition, and will not be sold, published, or used in any other way, other than patient care.

Given the conditions discussed, I hereby:

☐ Give my consent to ***Abba Hospice, Inc.*** to take photograph/s if applicable.

☐ Refuse to give my consent to ***Abba Hospice, Inc.*** to take any photograph/s.

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by

Abba Hospice Inc. to begin on _____
(Hospice Agency) (Effective Date of Election)

Note: The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

_____ _____
Signature of Patient / Patient Representative **(Date Signed)**

☐ Beneficiary is unable to sign - Reason:_____

_____ _____
Signature of Hospice Representative **(Date Signed)**

_____ _____
Witness signature **(Date Signed)**

ABBA HOSPICE, INC.

20955 Pathfinder Rd. Suite 332, Diamond Bar, CA 91765
Tel # 909-468-2033 Fax # 909-468-2018

PATIENT CONSENT FOR PRIMARY CARE PHYSICIAN

Patient Name: _____ **MR #:** _____

Physician's Name: _____ **Date:** _____

☐ I wish to continue my Primary Care with my current Physician.

Primary Care Physician: _____

NPI: _____

☐ I would prefer **ABBA Hospice, Inc.,** Medical Director to attend to my care needs.

☐ I would prefer **ABBA Hospice, Inc.,** Medical Director to intercede for only my terminal illness treatment needs and pain management.

Comments:

_____
_____
_____
_____
_____

_____ _____
Patient/Legal Guardian Signature Date:/Time

_____ _____
Hospice Representative Signature Date:/Time

ABBA HOSPICE, INC.

20955 Pathfinder Rd. Suite 332, Diamond Bar, CA 91765
Tel # 909-468-2033 Fax # 909-468-2018

Individual Patient Emergency Preparedness Plan

Identifying Information

Patient Name:_____ SOC Date:_____
Phone Number:_____ Physician:_____
Address:_____
City:_____ State:_____ Zip:_____

Relevant Healthcare Information

Primary Dx:_____Secondary Dx:_____
Daily or more frequently Agency Services: No____ Yes____
If Yes, describe:_____
Oxygen dependent: Flow Rate_____ Hours of Use:_____ Delivery Device:_____
Life-Sustaining Infusion: No____ Yes____
If Yes, describe:_____
Other IV Therapy: No____ Yes____
If Yes, describe:_____
Patient/Caregiver Independent: No____ Yes____
Ventilator Dependent: No____ Yes____
Dialysis: No____ Yes____
If Yes, describe:_____
Tube Feeding:No____ Yes____
If Yes, describe:_____
Patient/Caregiver Independent with Self-Administered Medications: No____ Yes____
Functional Disabilities (check all that apply): ____Walker/cane ____Wheelchair ____Bedbound
____Hearing Impairment ____Visual Impairment ____Mental/Cognitive Impairment

Emergency Plan

Emergency Contact Name: _____ Phone Number: _____
If necessary, patient will evacuate to: Relative/Friend
(Name/PhoneNumber):_____
Hotel (Name / Phone Number): _____
Shelter (Location):_____
Is patient registered for special need shelter? No____ Yes____
Other (Describe):_____

Priority/Acuity Level: _____

_____
Clinician/Date

*Copy to patient and original on medical record.

ABBA HOSPICE, INC.

20955 Pathfinder Rd. Suite 332, Diamond Bar, CA 91765
Tel # 909-468-2033 Fax # 909-468-2018

PATIENT ACKNOWLEDGEMENT

Patient's Name: _____
MR # _____ Date: _____

I have received the following information and have been given the opportunity to ask questions.

IMPORTANT INFORMATION EXPLAINED TO PATIENT/ FAMILY/ CAREGIVER	Explained	Left in Home
1. Patient's freedom of choice in selecting a hospice agency.		
2. Patient's condition/plan of care/goals and how related to his / her condition.		
3. Patient's right to participate in the plan of Care, treatment, and informed of Change.		
4. Patient/Caregiver is expected to learn and participate in care consistent with capabilities.		
5. Disease process, medication regime and diet.		
6. Written notice of Patient's Rights & Responsibilities, Consent, Assignment of Benefits, Patient grievance Procedure. Guidelines for Patient care and Emergency Care.		
7. Advance Directive. Has Patient executed an Advance Directive? YES, NO • Given written materials about right to accept or refuse medical treatment • Been informed of rights to formulate Advance Directives. • That patient is not required to execute an Advance Directives to receive medical treatment from this health care facility. • That the terms of any Advance Directives executed will be followed by the agency and caregivers to the extent permitted by laws.		
8. Visit Plan to include disciplines and frequencies.		
9. Confidentiality and Disclosure of Clinical Records.		
10. Basic Home Safety, Infection Control, Disaster Plan		
11. Patient liability for payment and right to be informed of any changes.		
12. Toll-free State Hospice Hot Line number and purpose.		
13. How to register a complaint with the agency and their right to voice grievance without fear of reprisal.		
14. Discharge Planning.		
15. Emergency Disaster Plan Priority Code: Good support system, efficient caregivers in place (Lowest Priority) Support system in place requiring frequent agency interventions (High Priority) Support systems unreliable and inconsistent and/or on 0_2, Infusion, or ventilator Therapy (Highest Priority)	Circle One Category 3 Category 2 Category 1	

Patient/Caregiver Signature: _____ Date: _____

Staff Signature/Title: _____ Date: _____