HOSPICE CARE CONSENT FORM

Patient Information			
First Name	**Last Name**	**Date of Birth**	
Street Address	**City**	**State**	**Zip Code**

I, , agree with the following statements:

I understand the care I receive from the Hospice is not directed to extending the length of life or reversal of the disease that I am suffering. But, the Hospice program is directed to a greater degree of symptom control that includes the relief of pain, creation of an environment for myself and my family to relieve stress and promote support.

I understand there will not be extraordinary life saving measures like cardiopulmonary resuscitation. I understand the limits of the program the Hospice provides.

After entering the Hospice program, I understand my attending physician will prescribe the extent and nature of my care and treatment and the Hospice is not liable for any act or omission in following his instructions.

I give permission to the Hospice to obtain personal/medical information and release this information to any relevant health care organization or physician.

I consent to my care and treatment in the Hospice program under the above conditions, and I hereby release the Hospice, its officers, and employees from all liability regarding the program's limitations to relieve my pain and making me comfortable.

I have been given an opportunity to ask questions that I have concerning the Hospice program.

I have been provided with a document about my rights and responsibilities as a patient. I have read and understood the document.

I have read and understand all the above statements and I hereby sign this consent of my own free will.

Signature: **Signature Date:**