Symponia Hospice
we are compassion

Patient Information Form

ADMISSION

Admit Date:	Level of care:		MR#:
Name:		Sex: M F	Date of Birth:
Address:		County:	
City:	State:	Zip Code:	ALLERGIES:
Telephone #	Ethnicity:		SS#:
Religion:	DNR? Yes No	Living Will Yes No	Disaster Level L M H
Marital Status:	Single Married Legally Separated Divorced Widowed Unknown		
Hospice Diagnosis:	ICD - 9 Code:	Date:	Facility:

PHYSICIAN INFORMATION

Referring Physician:		Phone #:	
Address:		Fax #:	
Hospice Attending Physician:		Phone #:	
Address:		Fax #:	
Primary Pay Source:		Group / Policy #:	
Secondary Pay Source:		Group / Policy #:	
Other agency involved? Y N	Name:	Funeral Home:	
Phone #:	Service:	Phone #:	

FAMILY / FRIEND INFORMATION

Name #1:		Name #2:	
Relationship: Guarantor – Y N	PCG?	Relationship:	PCG?
Next of Kin? Y N	Same Address? Y N	Next of Kin? Y N	Same Address? Y N
Address:		Address:	
City:		City:	
State:	Zip Code:	State:	Zip Code:
Cell Phone #:		Cell Phone #	
Work Phone #:	Home Phone #:	Work Phone #:	Home Phone #:
E-mail:		E-mail:	

Created:
Updated:

Symponia Hospice Election Statement

Patient Name: _____

Hospice Agency Name: _____

Hospice Election

I, _____ **(Patient Name)** choose to elect the Medicare hospice benefit and receive Hospice services from _____ **(Name of Hospice Agency)** to begin on _____ **(Start of Care Date)**.

(Note: The start of care date, also known as the effective date of the election, 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.)

Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician
☐ I acknowledge that my choice for an attending physician is:
(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- I was provided information on which items, services, and drugs the hospice will cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual and, in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions continue to be eligible for coverage by Medicare under separate benefits.

Symponia Hospice Election Statement

Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- The hospice must furnish this notification within 5 days, if you request this form on the start of care date, and within 72 hours (or 3 days) if you request this form during the course of hospice care.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:

BFCC-QIO Name: _____

BFCC-QIO Phone Number: _____

Signature of Beneficiary: _____

Date Signed: _____

☐ Beneficiary is unable to sign

Signature of Representative: _____

Date Signed: _____

Symponia Hospice
we are compassion

PATIENT CONSENT AND AUTHORIZATION

Patient Name _____ **MR #** _____

I consent to have services provided for me and I understand the nature and philosophy to be as follows:

1) I understand that hospice care is **not intended to be curative**, but the goal is to provide **supportive care** for people who have an incurable illness. I further understand that Hospice provides emotional, social, and spiritual support not only for me, but **also for my family** and others closely involved in my life.
2) I understand services will be **provided in my place of residence**, or a hospice contracted inpatient facility.
3) I understand that the hospice team is **not intended to take the place of family**, assisted living or nursing home staff, but rather support the primary caregiver(s) in the care of the patient.
4) I understand that the hospice Interdisciplinary Team includes **nurses, social workers, home health aides, chaplains and volunteers**. Specialty team members such as dietitians and physical/occupational therapists may also assist when appropriate.
5) I understand **preauthorization** from the hospice team is necessary should I elect to receive or undergo medical tests and services primarily curative in nature and not in accordance with the plan of care designed for me by the hospice team. I further understand that I may be financially responsible for such services should preauthorization not be obtained.
6) I understand that the **Hospice Medical Director** in consultation with other members of the Interdisciplinary Team (including my attending physician) will coordinate my hospice care services.
   I have received a copy of the hospice **Disaster Plan** and understand what my duties are in the event of an emergency.
7) I have received a copy of the **Patient/Family Rights** with explanations and I understand them.
8) I have been given the **opportunity to ask questions** about my care from hospice and all questions have been answered to my satisfaction.

AUTHORIZATION FOR BILLING AND MEDICAL RECORD RELEASE:

( ) **MEDICARE**: I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of all records required to act on this request & that payment of authorized benefits be made on my behalf.

( ) **MEDICAID**: I authorize release of all records from hospice to facilitate collection of payment for services rendered under Title XIX for the Social Security Act.

( ) **INSURANCE**: I authorize release of all records from hospice to _____ Insurance Co. and to Case Management _____ to facilitate collection of payment for services. I authorize the above company to pay directly to Hospice all payments due for services rendered.

I do not object to an agent of GA Dept. of Human Resources and other certifying and accrediting bodies reviewing my medical record and visiting my place of residence to ensure the state and federal requirements are met.

_____	_____	_____
PATIENT / LEGAL REPRESENTATIVE SIGNATURE	RELATIONSHIP	DATE
_____	_____	_____
HOSPICE REPRESENTATIVE SIGNATURE	TITLE	DATE

Created:
Updated:

Symponia Hospice
we are compassion

Do-Not-Resuscitate Order

Patient Name:_____

I, (Patient/Patient's Representative) _____
request limited health care as described in this document.

Choose the following:

☐ **If** (the patient listed above) heart stops beating or if (the patient listed above) stops breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel. This document does not refer to or include measures that will provide nutritional support or relief of pain.

I understand that I may revoke this consent at any time in one of the following ways: If under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

If not under the care of a health care agency, by destroying my do not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying the attending physician of the revocation.

OR

☐ **Patient chooses full code status. If** (the patient listed above) heart stops beating or if (the patient listed above) stops breathing, patient chooses to receive medical procedures to restore breathing or heart function by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers.
I hereby state that I am making an informed decision and agree to a do-not resuscitate order.

_____ _____
Patient/Patient Representative Signature Date

_____ _____
Signature of Witness Date
(This DNR Consent Form was signed in my, the witness's presence)

_____ _____
Physician's Signature Date

MRN:_____

Created:
Updated:

Symponia Hospice
we are compassion

Patient and Family Rights

Name:_____ MR#_____

Hospice patients have a right to be notified in writing of their rights and responsibilities in advance of receiving care and to exercise those rights. The patient's family or guardian may exercise the patient's rights when the patient is incapacitated. Hospice providers have an obligation to protect and promote the patient's rights.

- Patients and families have the right to participate in hospice voluntarily and to sever the relationship with the hospice at any time.
- Patients and families have the right to receive only the care and services to which the patient and/or the patient's family have consented.
- Patients and families have the right to receive care in a manner that patient's dignity, privacy and safety to the maximum extent possible.
- Patients and families have the right to receive hospice services in a manner that neither physically nor emotionally abuses the patient, nor neglects the patient's needs.
- Patients and families have the right to receive care free from unnecessary use of restraints.
- Patients and families have the right to have addressed and resolved promptly any grievances, concerns, or complaints and receive education in the availability and use of the hospice's grievance process.
- Patients and families have the right to refuse any specific treatment from the hospice without severing the relationship with the hospice.
- Patients and families have the right to choose their own private attending physician, so long as the physician agrees to abide by the policies and procedures of the hospice.
- Patients and families have the right to exercise the religious beliefs and generally recognized customs of their chose, not in conflict with health and safety standards, during the course of their hospice treatment and exclude religion from their treatment if they so choose.
- Patients and families have the right to have their family unit, legal guardian, if any and their patient representative present any time during an inpatient stay, unless the presence of the family unit, legal guardian, if any or patient representative poses a risk to the patient or others.
- Patients and families have the right to participate in the development of the patient's plan of care and any changes to that plan.
- Patients and families have the right to have maintained as confidential any medical or personal information about the patient.
- Patients and families have the right to continue hospice care and not be discharged from the hospice during periods of coordinated or approved appropriate hospital admissions.

Created:
Updated:

- Patients and families have the right to be provided with a description of the hospice services and levels of care to which the patient is entitled and any charges associated with such activities.
- Patients and families have the right to review, upon request, copies of any inspection report completed within two years of such request.
- Patients and families have the right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services.
- Patients and families have the right to continue to receive appropriate care without regard for the ability to pay for such care.
- Patients and families have the right to have communication of information provided in a method that is effective for the patient. If Symponia Hospice cannot provide communications in a method that is effective for the patient, attempts to provide such shall be documented in the patient's medical record.

Complaints may be reported 24 hours a day at 404-657-5726 or 404-657-5728.
The email address to report complaints to the Healthcare Facility Regulation Division is HFRDComplaintIntake@dch.ga.gov.

____ I have been given a copy of the Patient/Family Rights and I understand the meaning of those rights.

_____ _____

Signature of Patient/Resident/Designated Signature Date

_____

Printed Patient Name

_____ _____

Signature of Hospice Representative Date

Created:
Updated:

Symponia Hospice
we are compassion

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

Created:
Updated:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Created:
Updated:

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls

Created:
Updated:

- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

_____(Initials) I have received and reviewed a copy of the privacy policy.

_____ _____

Patient or Representative Signature Date

_____ _____

Hospice Representative Date

MRN:_____

Patient Advance Directives Statement

I understand that an advance directive includes:

- A living will.
- Durable power of attorney for health care.
- Any other written document executed by the patient, signed and dated that express the patient's health care treatment decisions.

I understand that additional information is included in my Hospice folder.

I understand that Hospice will honor all of my advance directives.

❑ I would like more information regarding advance directives.

❑ I would like to execute one or more advance directives.

❑ I have a living will: Yes _____ No _____
If Yes: copy obtained: Yes _____ No _____
If No: describe patient's wishes _____
_____
_____

❑ I have a durable power of attorney: Yes _____ No _____
If Yes: Name _____ Telephone _____

❑ I have an advance directive: Yes _____ No _____
If Yes: copy obtained Yes _____ No _____
If No: describe patient's wishes _____
_____
_____
_____

I have reviewed and understand my Patient/Family Rights as described above and have been given written information concerning advance directives and my rights and responsibilities.

_____ _____
Patient Signature Witness Signature

_____ _____
Date Date

MRN:_____

Created:
Updated:

Symponia Hospice
we are compassion

MEDICARE SECONDARY PAYER WORKSHEET

KEY: WC= Workers Compensation
BL = Black Lung
GHP = Group Health Plan
DVA=Department of Veterans Affairs
ESRD= End Stage Renal Disease

Patient Name: _____ Patient ID: _____

PART I: Was Illness/injury due to **Work Related Accident/Condition** and covered by WC plan, DVA or the Federal BL program?

☐ NO Continue to **Part II**

☐ YES Name & Address of: ☐WC ☐DVA ☐BL Pgm. (check all that apply)

_____ Policy or ID#: _____

Part II: Was illness/injury due to a **NON – Work Related Accident/Condition?**

☐ NO Continue to **Part III**

☐ YES What type of accident caused the injury? ☐Automobile ☐Non – Automobile

Accident Location: ☐ Home ☐ Business ☐ Other: _____ Date of Accident/ Injury: _____

Describe Accident /Injury: _____

☐ Automobile? Name, Address & Phone # of Insurer: _____

Insurance Claim number: _____

YES: *STOP* AUTO INSURER IS PRIMARY PAYER FOR ACCIDENT RELATED CLAIMS (Go to **PART III**)

☐Non – Automobile? Was another party responsible for this accident?

Name, Address & Phone # of any liability Insurer: _____

Insurance Claim number: _____

STOP ***ANOTHER PARTY IS PRIMARY PAYER FOR ACCIDENT RELATED CLAIMS*** *(Go to **PART III**)*

PART III: Is Patient **Entitled to Medicare Based on Age** (age 65 or Over)? (If Yes, answer questions 1-3)

☐ NO (Under age of 65) **Continue to Part IV**

☐ YES: 1. Is the patient ☐ employed ☐ retired and covered by GHP or HMO? ☐Yes ☐No

(retirement date: _____) ☐No *Never worked*

Or 2. Is the patient covered under spouse's GHP or HMO? ☐Yes ☐No

Or 3. Has the patient chosen a HMO to manage their Medicare benefits? ☐Yes ☐No

and Does the GHP employ 20 or more? ☐Yes ☐No

STOP ***GHP/HMO IS THE PRIMARY PAYER FOR ACCIDENT RELATED CLAIMS*** *(Go to **PART VI**)*

PART IV: Patient Is a **Disabled Medicare Beneficiary Under Age 65.**

And 1. Is the patient covered by GHP or HMO? ☐Yes ☐No (GHP employs 100 or more ☐Y ☐N)

Or 2. Is the patient covered under spouse's GHP or HMO? ☐Yes ☐No (GHP employs 100 or more ☐Y ☐N)

☐No *STOP* **MEDICARE IS THE PRIMARY PAYER** (Questions 1&2 an NO) (Unless Part I and II were answered Yes) ☐Yes: Continue to **Part V** (and complete ***PART IV)***

Part V: Is Patient entitled to Medicare based on **End Stage Renal Disease (ESRD)**? (Primary Payer Determination)

☐No: *STOP* **MEDICARE IS THE PRIMARY PAYER**

☐Yes: 1. Is the patient within the 30-month coordination period? (I.e. 30 mo. from initiation of dialysis) ☐Yes ☐No

2. Was the patient's initial entitlement to Medicare based on ESRD? ☐Yes ☐No

3. Does the working aged or disability MSP provision apply? ☐Yes ☐No

STOP ***GHP/HMO IS THE PRIMARY PAYER DURING THE 30 MO. COORDINATION PERIOD.*** **(1&2 OR 1&3 IS yes)**

PART VI. GHP/HMO INFORMATION

Name & address of GHP/HMO:

Patient's ID Number:

Policy Holder / Relation to Patient:

Signature/Title:_____ **Date:**_____

Created:
Updated:

Symponia Hospice
we are compassion

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name:	Date of Birth
Social Security Number:	Phone Number (C) (H)
Contact Person (If other than Patient)	Contact's Phone:

Medical Information

	Complete Medical Record		Demographic/Visit History
	Discharge/Transfer Summary		X-Ray
	Lab		Abstract of Medical Record
	History & Physical Exam		EKG
	Pathology Reports		Operative Reports
	Consultation Report		Other:

I authorize Symponia Hospice to obtain my medical records (including medical information related to the diagnosis or treatment of my medical conditions) as specified above.

REASON FOR REQUEST: _____

DELIVERY MODE

_____ Call _____ when photocopies are available for pick-up

_____ Please FAX records to: _____

_____ Please mail records to: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Symponia Hospice, LLC. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect, or receive copies of the information to be used or disclosed, as provided in CFR 164524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at 770-485-9186.

Patient/Legal Representative Signature_____

Legal Relationship: _____Date: _____

Created:
Updated:

Management and Disposal of Controlled Drugs for Patients and Families

We are providing you this policy to assist you in storing your controlled (e.g., narcotic) medications:

Storage:

- Store tablets and liquids at room temperature, in a cool dry place, away from heat or light. May store in the bathroom in medication cabinet. Store suppositories in the refrigerator.
- Medications stored in refrigerator should be stored away from food items, with proper labeling.
- Keep all medications out of reach of children and/or persons with altered mental status.
- Follow specific guidelines for storage and handling given by the pharmacy.
- Consider using a locked box to store controlled medicine to prevent this medicine from being stolen or taken by anyone other than the patient.

Disposal of controlled substances:

- Take unused, unneeded or expired prescription drugs out of their original container and throw them in the trash.
- Mixing prescription drugs with an undesirable substance, such as used coffee grounds or kitty litter, and putting them in impermeable, non-prescript containers, such as empty cans or sealable bags, will further ensure the drugs are not diverted.
- Flush prescription drugs down the toilet only if the label or accompanying patient information specifically instructs doing so.

  Fentora (fentanyl buccal tablets)

Note: Patients should always refer to printed material accompanying their medication for specific instructions.

This policy has been discussed with me.

_____ _____

Patient/Caregiver Signature/Date *Hospice Nurse Signature/Date*

*Note: One copy to patient record and one copy to patient.

Created:
Updated:

DISASTER PLANNING GUIDELINES: PATIENT/CAREGIVER HANDOUT

Patient Name:_____ MR#_____

Disaster Planning Guidelines:

1. Keep an emergency kit in your home. Include in it the following items.
   a. Flashlight and batteries
   b. Portable radio with batteries
   c. Bottled water
   d. First aid kit
2. If a storm is approaching the area, listen to weather updates frequently.
3. Do not let medications fall below a three-day supply before refilling.
4. If a disaster situation occurs, our agency will attempt to contact you. If you have left your home and are at a different location, please call our agency and inform the staff of your location. If the agency is unable to contact you due to loss of telephone service, we will be attempting to make the local EMS aware of any of our patients who may need immediate attention. If telephone service is interrupted, you should try to tune in to a local radio station for possible information updates related to the disaster occurrence.
5. We provide a listing of Emergency telephone numbers. As long as telephone lines are intact, we ask that you contact our agency for any medical needs, so that we may assure that you receive the assistance you need.

EMERGENCY TELEPHONE NUMBERS:

AGENCY OR SERVICE	TELEPHONE NUMBER
Hospice (24 hours/ 7 days per week)	
Sheriff's Department	911
Fire Department (information)	911
Fire and Police Emergencies (EMS #) 911	911
Electric Service	
Gas Service	
Radio Station (on am dial)	
Television Station	

_____ _____

Patient or Caregiver Signature Date

_____ _____

Hospice Representative Signature Date

Created:
Updated:

Symponia Hospice
we are compassion

MEDICARE REVOCATION / TRANSFER OF HOSPICE BENEFIT

Patient Name: _____ MR#: _____

Address: _____

Medicare #: _____ Social Security No:_____

I, _____, desire to voluntarily revoke / transfer the election (Patient/Primary Care Giver)

of Hospice care being provided for _____.
(Name of Patient)

This Revocation / Transfer shall be effective as of ____/____/____.

☐ (Check here for Revocation)
I understand that upon revocation of the hospice benefit for this particular election period, there will no longer be coverage for hospice, and that coverage of benefits that were waived at the time of hospice election will resume. When revocation occurs before an election ends, the remaining days for that period will be lost. I also understand that I may at anytime reelect to receive hospice services, if I meet admission criteria.

OR

☐ (Check here for Transfer)
I understand that I am choosing to transfer from:

_____to: _____
(Current Hospice Provider)(New Hospice Provider)

to receive hospice services under my Medicare hospice benefit.

I have been given opportunity to discuss the terms of this statement with a hospice representative and I fully understand the terms of this statement.

I, therefore, revoke / transfer the hospice benefit due to:

_____

_____

_____ _____
Signature of Patient/Primary Care Giver Date

_____ _____
Signature of Hospice Representative Date

Created:
Updated:

Symponia Hospice
We are Compassion

PRIMARY CERTIFICATION

Admitting Diagnosis: _____ ID-9 Code:_____

Patient Name: _____ Record#:_____

Start of Care:_____ Attending Physician:_____

- I hereby certify to the best of my ability within the realm of current medical records, that the prognosis indicates a life expectancy of six months or less, provided the disease continues on its normal course of progression.

- Clinical information and other documentation support the terminal condition and co-morbidities.

Verbal order received by: _____

Yes ☐ No ☐ I will turn over care to the Hospice Medical Physician to manage all medical certification, pain control, and symptom management for all diagnoses.

Signature: _____ Date: _____