

Informed Consent Form

Te Omanga Hospice (ToH) provides specialist palliative care for people living with a life limiting illness. Our **focus is your quality of life, relieving symptoms** which cause distress or discomfort, and **ensuring you and your family are well supported.**

In order to co-ordinate your care effectively Te Omanga Hospice clinicians will share relevant health information with other health professionals involved in your care; e.g. your local hospital, general practitioner and amongst our interdisciplinary team.

The Health Information Privacy Code 1994 protects your right to confidentiality and ensures collection, use, storage and disclosure of information is appropriate. If staff have serious concerns for your safety or the safety of others they may ask other appropriate professionals to be involved in your care.

- I have been fully informed of the service and care I will receive and have had any questions answered by a member of the clinical team.
- I have been fully informed about my rights and have the Code of Health & Disability Services Consumer Rights
- I am consenting to care that focuses on my quality of life, comfort, dignity and symptom management through to my death.
- I understand that measures will not be taken to hasten my death or prolong my life.
- I will be involved in planning my current and future care with the clinical team.
- I will be given the opportunity to discuss the care I am to receive and to have any questions answered.
- I will be kept informed about my current medical status and appropriate treatment options.
- I understand that if I withhold information relevant to my health this may impair the ability of ToH staff to provide the best care for me.
- I can expect that any transfer between providers of care will be fully explained and discussed with me.
- My approval will be sought prior to medical or nursing students (under the supervision of Hospice staff) being present or assisting in my care.
- In addition to this written consent (to service delivery) further explanations and verbal consent will be obtained for some interventions (complex procedures).
- In the event of staff injury involving contact with my blood or body fluids I understand a blood sample, to test for infectious diseases, may be necessary. The purpose of this is to ensure safety of the staff member.

Name of Patient: _____

NHI No: _____

Family/whanau/friends with whom we can share information:

People with whom we cannot share information:

Name of Patient _____

I, _____ consent to the services offered by Te Omanga Hospice
(name of signatory)
Specialist Palliative Care Service.

(Tick classification of signatory)

- Patient
- Enduring Power of Attorney activated
- Parent/Legal Guardian
- Court Appointed under PPPR
- Person nominated by patient at the time of consent

Signature: _____

Date _____

Staff /Witness Signature: _____

Name: _____

Designation: _____

If the signatory is not the patient briefly state reason that the patient is unable to give consent, in the section below: