

Hospice Care Patient Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

Consent for Hospice Care

I, the undersigned, hereby give my consent for hospice care services to be provided to me, as per the plan outlined by my healthcare team.

Scope of Services:

- Medical care and pain management
- Psychosocial support
- Spiritual counseling
- Family support services

I understand that:

- Hospice care focuses on improving quality of life.
- I have the right to withdraw my consent at any time.
- My care will be tailored to meet my individual needs.

By signing below, I acknowledge that I have read and understood the information provided and consent to receive hospice care services.

Patient Signature: _____

Healthcare Provider Signature: _____

If the patient is unable to sign, please complete the following:

Legal Representative Name: _____

Relationship to Patient: _____

Signature of Legal Representative: _____

Contact Information

Phone Number: _____

Email: _____

Thank you for choosing our hospice care services.