FWC HOSPICE ADMISSION APPLICATION

Please complete this form and return to the hospice. All the information requested on this form is relevant so please ensure that all questions are answered and all documentation provided. Completion of this form does not guarantee admission to the hospice.

PERSONAL & FINANCIAL DETAILS (PATIENT)			
Full Name and Surname			
Address **(Proof of residence to be attached)**			
Telephone Number/s			
Date of Birth		**Age**	
ID Number (certified copy to be attached)			
Marital Status			
Name of husband/wife			
Do you have children? **If yes, how many?**	❑Yes ❑No		
Type of Pension			
Authority Number Amount			
Office at which it is drawn			
Certified correct date **Commissioner of Oaths**			
If you receive a private pension, please state **Source of Pension** **Ref Number** **Amount**			
NEXT OF KIN INFORMATION (RESPONSIBLE FOR PAYMENT OF THE ACCOUNT)			
Full Name and Surname			
Relationship to patient			
Address **(Proof of residence to be attached)**			
ID Number (certified copy to be attached)			
Phone Number/s		**Landline:** **Cell:**	
Email Address			
Do you have Power of Attorney	❑ Yes ❑ No **Type:** ❑Medical ❑Financial ❑ General decisions		
Does any other member of the family have POA	❑ Yes ❑ No **Type:** ❑Medical ❑Financial ❑ General decisions		
Method of payment	❑ EFT (preferred method) ❑ Pension Card ❑ Cash		

MEDICAL HISTORY/DIAGNOSIS	
Medical conditions (Diagnoses)	
Is patient ambulant **What aides are used**	❑Yes ❑No ❑Walking stick ❑Frame ❑Wheelchair
Eyesight **Vision aides**	❑Good ❑Fair ❑Poor ❑Spectacles ❑Contact lenses ❑None ❑Other (specify):
Hearing **Hearing aides**	❑Good ❑Fair ❑Poor ❑Deaf ❑None ❑Hearing aid ❑Sign language ❑Other (specify):
Speech **Speech aides**	❑Good ❑Fair ❑Loss of speech ❑Hand signals ❑Writing
Sleep	❑Sleeps well ❑Sleeps poorly ❑ Takes medication to sleep
Assistance required	❑Yes ❑No ❑Bathing ❑Dressing ❑Feeding ❑Personal Hygiene
Do you smoke	❑Yes ❑No
Do you drink alcohol	❑Yes ❑No
Have you ever been treated for drug or alcohol addiction	❑Yes ❑No Further Comments:
Allergies **Also state reactions** ***e.g. Itching, loss of breath***	
Meal portions **Preferences**	**❑Small ❑Normal ❑Large** **❑Tea** ❑Coffee

(**NB: Clinical exclusions of patient information may compromise proper assessment**)

MEDICAL REFERRAL/CERTIFICATE ***This section is to be completed by a Medical Practitioner***	
Full name of patient	
Date of Birth	
Gender	
Complaints, history, symptoms and previous treatment including details of operations and hospital stays (if TB: has it been registered?)	
General Examination ***Physical & Nutritional State, Waisted / Obesity***	
Respiratory System (Does the patient require administration ventilation (O2)	
Cardio vascular system	
Blood Pressure	
Genito-urinary system (urine to be tested)	
Digestive and other abdominal systems	
Hernia	
Muscular and skeletal systems (state defects) (*e.g. old* fractures)	
General nervous system In cases of Epilepsy state particular type, severity, frequency of attacks and response to treatment	
Mental condition including mental deficiency – state particular type and mental age. List any previous psychotic or psychoneurotic episodes with dates if possible	
List of current medications	

Doctor's Signature: _____

Doctor's Name: _____

Date: _____

Doctor's Stamp

NB. (Clinical exclusions may compromise proper assessment)

SOCIAL PROFILE *This section's information is for us to gain insight to the patient's preferences for recreational purposes*	
Previous occupation/s	
Hobbies and interests **Eg: Gardening, art, world news, travel**	
Skills **Eg: Carpentry**	
Social interaction	
Religious beliefs	

Tell us more about yourself (likes/dislikes, etc)

REPORT BY SOCIAL WORKER

The Social Worker is required to give an accurate assesment of the applicant and his/her need for placement in a hospice

_____ _____

Signature of Social Worker Print name of Social Worker

_____ _____

Name of Organisation Address

_____ _____ _____

Phone number/s Fax Email

FINANCIAL AGREEMENT AND INDEMNITY

1. I _____(**Full name and Surname**) am fully aware of the fees and charges prevailing at FWC Hospice.
2. I, the undersigned, will be responsible for payment of all such charges and disbursements in connection with me/or the said patient.
3. I undertake to make payments, if required, to maintain the account in credit, and to pay the account in full before leaving the hospice EXCEPT where alternative arrangements acceptable to the Hospice have been made.
4. I am aware that the patient is under the control of his/her attending Medical practitioner and that the Hospice is not liable for any act or omission in following the instructions of said Medical practitioner.
5. I understand that all doctors of medicine furnishing services to the patient are independent contractors and not employees or agents of the Hospice, and those fees for their services are separate and payable by the patient or NOK.
6. I have read this document and am fully aware of ALL terms and conditions thereof.
7. I acknowledge that neither the Hospice nor its employees shall be responsible for loss of money, valuables or other property belonging to or in possession of the patient, unless those are deposited with the Hospice for safe keeping and a receipt obtained thereof.

DEPOSIT REQUESTED
Patients who do not satisfy the Hospice requirements regarding Medical Aid membership or sponsorship will be asked to lodge a deposit equivalent to the estimated fee or the estimated shortfall.

ACCOMMODATION
It is not possible for FWC Hospice to accept a contractual obligation in regard to preferred ward accommodation. The Hospice will make every effort to provide the preferred accommodation type, either on admission or as soon as possible. Please note if a Private Room is required an additional deposit will be requested before admission.

VALUABLES
Patients are requested to bring as few items of value as possible. The Hospice hold no responsibility for any losses, unless officially handed in for safe keeping.

I CERTIFY THAT ALL THE PARTICULARS PROVIDED ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND THAT IN PARTICULAR, I UNDERSTAND AND ACCEPT OF THE ABOVE AGREEMENT.

_____	_____
Name of Patients Representative/NOK	Name of Witness (Admission Clerk)
_____	_____
Signature	Signature
_____	_____
Date	Date

PERSON RESPONSIBLE FOR FEES

I CERTIFY THAT ALL THE PARTICULARS PROVIDED ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND THAT IN PARTICULAR, I UNDERSTAND AND ACCEPT SECTION 8 OF THE ABOVE AGREEMENT.

_____	_____
Name of Patients Representative/NOK	Name of Witness (Admission Clerk)
_____	_____
Signature	Signature
_____	_____
Date	Date

FOR OFFICIAL USE
Checked Patient's ID? ❑Yes ❑N

Policy Title	Access to Palliative Care Services – Service fees and costs		
Policy Number	6.1.1		
Service Element	Access to Care and Patient rights		
Date Implemented	23.01.2018	**Review Date**	06.03.2019

POLICY

PROCEDURE

Family worship centre hospice is a 45 bedded in-patient unit. We offer 24 hour service, in a homely environment.

FWC has a duty of care to their patients and the implementation of these guidelines ensures that their health and safety needs are being met. Patients and family members are required to agree and adhere to these guidelines as part of the admission process.

- *FWC is a non-smoking facility therefore smoking is prohibited anywhere on the property. Patients found smoking on the property will be discharged immediately.*
- *Alcohol and drugs are not allowed in the facility or anywhere on the property. Patients who are caught drinking or using drugs on the property will be discharged immediately. (this applies to Visitors as well).*
- *Storage of any food, alcohol and drugs in the rooms and lockers are not allowed.*
- *All toiletries are to be provided by the family, (It must be recorded into the Visitors book that FWC has received it). Same applies to any clothing items brought.*
- *No cash is allowed to be given to a patient.*
- *Staff are not allowed to accept gifts from patients or visitors either monetarily or kind.*
- *Visitors are not allowed in the patient's rooms except in certain circumstances where permission has been given by the Matron. The Community Room (sunshine room) and outdoor area is available during visits.*
- *Male and female patients are not allowed in each other's rooms.*
- *Patients are not allowed to leave the property under any circumstances unless accompanied by a staff member for hospital visits or family member for home visits. Nursing Manager must be notified and permission must be granted by signing an FWC indemnity form.*
- *Remember we here to give the best care possible and when the patient is in our care allow us to do our best!*

- *Patients and Visitors should not access areas that are restricted to staff only, e.g. kitchen, medication room and laundry.*

- *Visitors are to adhere to visiting hours **09h00 to 11h00 and 14h00 to 16h00 daily**, and adequate notification be given to the Nursing Manager for visits outside of these hours which will be 30 minutes only.*

- *All visitors are to sign the visitors' book on arrival.*

- *As a safety standard, patients are not permitted to bring in their own furniture. Electrical appliances and food. No cooking is allowed in the wards.*

- *Patients referred to Helen Joseph hospital will be transported in company vehicle at FWC costs, unless the patient is a special needs and requires an ambulance for transport – this must be arranged, paid for and administered by the family. To any other hospital/facility or doctor it will be by the family's arrangement who shall incur the cost and administration of such travel and consultation.*

- *Patients who are incontinent are to provide incontinence aids or arrange for purchase through the facility.*

- *Medication must be obtained privately. Patients that are registered with state hospitals are required to continue with and declare to the facility staff. Any non-scripted medication must be declared to the Matron, we prefer you not to bring any non-scripted medication to the patient.*

- *A "How we Doing"card is available for any comments to be placed in box in reception. Patient queries must be discussed directly with Matron and not with subordinates or Care Givers.*

- *National patients rights charter is adhered to at all times.*

*Current cost for the service is **R3600-00** inclusive per month payable in advance by the 3rd of each month with a 10% increase annually on the 1st March.*

Admission before the 15th = Full price and after the 15th = 50% (eg:R1800.00)

A receipt must be issued for any cash payments received.

Signed by:_____ Date: _____

Full Names:_____

Patient's Name:_____

Nursing Manager Name:_____Family Witness:_____