FWC HOSPICE

Corner Harmony & Retief Streets
HURSTHILL GAUTENG 2092
Phone: (011) 837 2999
Email: info@fwc.org.za

HOSPICE ADMISSION APPLICATION FORM

- Please complete this form and return it with all required documentation to the Hospice Admin staff.
- Ensure all sections are completed.
- Submission 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		
Medical Aid Name:			
Medical Aid Plan:			
Membership Number:			
Main Member:			
Main Member ID:			
Main Member email address:			
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	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 Power of Attorney	❑Yes ❑No Type: ❑ Medical ❑ Financial ❑ General decisions
Method of payment for fees/costs	❑ EFT (preferred) ❑ Pension card ❑ Cash
END-OF-LIFE DETAILS	
Funeral Director	
Funeral Director's phone number	

Please initial here _______________

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

Please initial here _______________

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)	
Cardiovascular 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: _______________

NB. (Clinical exclusions may compromise proper assessment)

Doctor's Stamp

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

Please initial here _______________

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 ❑NO

Please initial here ______________

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.

Patients medical information, status and general information is considered strictly private & confidential and not to be discussed with anyone besides the Nurse Manager.

1. Guidelines

- *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).*
- *Any physical violence example fighting, foul language or abuse will result in immediate discharge*
- *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.*
- *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!*
- *National patients' rights charter is adhered to at all times.*

2. Food

- *Storage of any food, alcohol and drugs in the rooms and lockers are not allowed.*
- *No cooked food is to be brought in for patients. Snacks, sweets, crisps, etc is allowed and must be recorded in the Patients Book located at Reception.*
- *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.*

3. Requirements and Provisions

- *All toiletries are to be provided by the family, (It must be recorded in the Visitors Book that FWC has received it). Same applies to any clothing items brought in.*
- *Patients and Visitors should not access areas that are restricted to staff only, e.g. Kitchen, Medication Room and Laundry.*
- *A limited amount of clothing items must be provided for the patient. Please ensure all items are clearly labelled with the patient's name and surname. (A 'Patients Personal Belongings Form' is to be completed).*
- *Patients referred to Helen Joseph hospital will be transported in company vehicle at FWC costs, unless the patient is a special need 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 Adult Nappies, Aids or arrange for purchase through the facility.*

Please initial here _______________

4. Visiting

Entering a hospice is a big change for your loved one. Sometimes it can cause feelings of abandonment for the patient. It is important that you maintain a regular visiting schedule with your family member to help them settle in and grow accustomed to their new surroundings. It is easy to become distracted with your other obligations, so setting a regular day/time will ensure that you have the time allocated and it helps the patient with their weekly routine.

Birthdays, Easter and Christmas *are special occasions and should be celebrated with all loved ones. Please consider taking your family member home at these times.*

- *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.*
- *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 ______________________ and adequate notification be given to the Nursing Manager for visits outside of these hours which will be 30 minutes only. Visits outside of these hours will be ___________________________________.*
- *All visitors are to sign the visitors' book on arrival & any snacks brought in must be recorded in the receiving book at reception*
- *A "How we Doing "card is available for any comments to be placed in box in Reception.*
- *PASS OUT: Patients can be taken home for a day or weekend visit. An Indemnity Form must be completed prior to the Pass Out date.*

Full Name: ______________________________________

Signature: _________________________________ *Date:* ________________________

*Patient's Name:*____

*Nursing Manager Name:*_________________________________

*Family Witness:*____

Please initial here ______________

DOCUMENTATION CHECKLIST

- ❑ Proof of residence – patient
- ❑ Certified copy of ID - patient
- ❑ Proof of residence – next of kin
- ❑ Certified copy of ID – next of kin
- ❑ Medical referral/certificate – to be completed by a Medical Practitioner
- ❑ Social Worker's report