

Sri Sathya Sai Palliative Care Center - Puttaparthi

Consent for Home Care Treatment

I _____(S/O,D/O, W/O) _____ resident of _____ give consent for home visit and palliative care treatment.

(if patient is not capable of giving consent)

I _____(S/O,D/O, W/O) _____ resident of _____ , on behalf of _____ (patient's name) and related to the patient as _____ , give consent for home visit and palliative care treatment.

1. I understand that during the home care visits, I will have access to Physician, Nurse, Physiotherapist, and Counseling services, as required for my care, but all may not be present on every visit.
2. I understand that this is not an emergency service and the frequency of home visits will be made based on the need of the patient as assessed by the Palliative Care Team and their availability.
3. I give consent for the performance of diagnostic tests, treatment and medical procedures as deemed essential by the treating doctor. Some of the procedures would include: Urinary Catheter Insertion/Change, Wound Dressing, Enema, Injections, Ascitic Tap, Stoma Care, Mouth Care, Lymphedema Care, Exercises etc.
4. I understand that the purpose of all treatment during home care visits is to relieve my suffering due to my disease and provide comfort as much as possible. No curative treatment for the primary disease is given by this service.
5. I will follow the treatments as advised and I give consent for follow-up through phone call and future visits.
6. I will not hold the service or the staff responsible or liable for any consequences of the treatment/disease.

I have been given the opportunity to ask questions and clarify doubts. I have been explained in my own mother tongue which I have understood.

Patient Signature/Thumb
impression

Relative/ Guardian
signature/thumb impression

Witness Nurse/Doctor

Contact No.
Date & Time