HOSPITAL IN YOUR HOME
Bringing the Hospital to you

ATTACH PATIENT LABEL HERE

WELCOME TO THE HOSPITAL IN YOUR HOME SERVICE. PLEASE TAKE THE TIME TO READ THIS CONSENT FORM THOROUGHLY BEFORE COMPLETING WITH YOUR SIGNATURE AND DATE AT THE BOTTOM. IF YOU HAVE ANY QUESTIONS PLEASE DO NOT HESITATE TO TALK WITH OUR STAFF.

WHAT IS HOSPITAL IN YOUR HOME (HIYH)
Hospital in Your Home (HiYH) is you receiving hospital level care in your own home. There is a HiYH nurse available 24 hours a day, 7 days per week by telephone while you are admitted to our service.

WHO WILL BE LOOKING AFTER ME ON HIYH
While you are on the HiYH program you will be seen by a highly qualified HiYH registered nurse who liaises on your behalf with our doctor and the referring hospital team. If required and mutually agreed you may also be seen by an allied health professional such as a physiotherapist.

TO BE ABLE TO HAVE HIYH WHAT WILL I HAVE TO DO
To be able to receive HiYH in your home you need to agree to do the following:

- I agree to follow the directions for taking my medication given by the pharmacy and the label on the packet.
- I agree to follow the recommended treatment pathway that the doctor from the hospital has put me on.
- I agree to store my medications as stated on the label on the box and that I will keep the label in place.
- I agree to keep all medications out of the reach of children at all times.
- I agree to notify my HiYH nurse at any stage I am feeling unwell as a result of taking my medication.
- I agree to tell the HiYH nurse if I wish to take any new medications that is not part of my normal day to day medication needs.
- I agree to not be under the influence of any illicit drug substances or alcohol and my home will be smoke-free during my HiYH visits.
- I agree to treat my Intravenous catheter with care and that I will not inject any substances or use this device in any way. All medications will be administered by my trained HIYH clinical staff member. I will notify HIYH if there are any concerns

TREATMENT

- I agree to give all information regarding my past medical history to my HiYH nurse prior to leaving the hospital.
- I agree to do my best to ensure I am home for my HiYH treatment visit and if I am not going to be I will let the HiYH team know as soon as able and when I will be home.
- I agree that if there is any change to my health I will call the HiYH 24-hour number or get my family member/carer to call on my behalf immediately.

I HAVE BEEN TOLD BY THE HIYH NURSE OR THE DOCTOR THE FOLLOWING:

- Why I need HiYH and what my medical condition is.
- What treatment I will be getting while on HiYH.
- What to do if I am worried.
- Who to contact if I need help.
- How I can access my medical information and that my medical record remains the property of the hospital.

CONSENT TO HIYH CARE AND SERVICES
I agree to allow HiYH clinical staff in consultation with the hospital doctor to provide me with care and services that will be identified and documented in partnership with me and my care plan and stored in my electronic medical record. I understand that I can ask for my care plan to be reviewed at any time during my HiYH care and that I can refuse/or stop the care and service provided to me by HiYH at any time. I agree that I will be going home with a peripheral intravenous catheter/CVAD device in place to receive my treatment and that I will notify HIYH of any issues with it and treat it with care.

CONSENT TO THE COLLECTION, USE, DISCLOSURE AND DISPOSAL OF MY PERSONAL INFORMATION IDENTIFICATION AND CLINICAL PHOTOGRAPHY

- I agree to the sharing of my personal information and care plan to any medical practitioner, ambulance service, hospital or service provider to assist in any current or future care services.
  I agree to having my photograph taken for identification purposes and that this will be stored on my electronic medical record and in my care plan and I understand that this will not be shared on any social media platforms.
- I agree that if required my HiYH nurse will take clinical photographs of my wounds for the purpose of my clinical management and these will be stored on my electronic medical record and I understand that this will not be shared on any social media platforms or shared with anyone that is not part of my current or future care services.

BY SIGNING THIS HIYH CONSENT FORM, I AGREE TO ALL OF THE ABOVE STATEMENTS AND REQUESTS AND AGREE TO ALLOW HOPSITAL IN YOUR HOME TO TREAT ME AT MY HOME.

PLEASE SIGN HERE

Patient Full Name: ____________________ **Signature**: ____________________ **Date**: __________
(or representative)

Relationship to Patient: ____
(if patient not signing consent/signed by representative)

Witness Name: ____________________ **Signature:** ____________________ **Date:** __________