AlfredHealth

☐ Alfred ☐ Sandringham ☐ Caulfield

Unit: Better at Home

UR

Family Name

Given Names

Address

Date of Birth

Sex ☐ Female ☐ Male ☐ Other

AGREEMENT FOR HOME THERAPY

I _____ (patient name) acknowledge that I have been assessed by a doctor and I have been advised by Alfred Health that I am medically stable and can receive treatment at home.

- I have read and I understand the Better at Home Patient Information brochure and I agree to receiving services as part of the Better at Home program
- I understand that a doctor will oversee my ongoing care while I am on the program
- I understand that I am admitted as an Alfred Health patient until discharged from the program
- I understand that I may be required to attend out-patient hospital appointments while on the program
- I understand that while I am on the program, all medical treatment is to be provided by the program doctor
- I agree that I must be at home when a home visit is expected
- I agree to ensure that my home is a safe and smoke free environment while any program service provider is present
- I agree to contact the program manager if I have concerns about any aspect of the program
- I understand that the program is time-limited and that program staff will actively put in place long-term arrangements to best suit my needs

_____

_____

_____

Patient signature _____ Date: __/__/__

Person Responsible* Name & Signature (*if applicable*) _____

Relationship to patient _____

Better at Home team member name _____

Better at Home team member signature _____ Date: __/__/__

Date Created: May2022
Printed from Intranet

EMR: Legal / Agreement *Person Responsible definition on AlfredHealth Connect

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