Home-Based Palliative Care Consent Form

| Patient Name: |
|-----------------------------------------------|
| |
| Date of Birth: |
| Date of Billin. |
| |
| Purpose of Care |
| Nature of Home-Based Palliative Care Services |
| Benefits and Risks |
| Alternative Treatment Options |
| Consent and Acknowledgment |
| Patient/Representative Signature: |
| |
| Date: |
| |
| Healthcare Provider Signature: |
| |
| Date: |
| Date. |