Respite Palliative Care Consent Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Primary Contact

Name

Relationship

Phone Number

Consent

I acknowledge that I have received information about respite palliative care services and understand the nature, purpose, benefits, and possible risks associated with this care.

Additional Information / Special Instructions

Authorization & Agreement

I voluntarily give my consent for the above-named patient to receive respite palliative care services. I understand that consent may be withdrawn at any time by notifying the care provider.

Patient/Representative Signature

Date

Witness Signature

Date