

Documentation of Patient Teaching

Patient's Name _____

I/we have been instructed and understand the safe use and maintenance of the following equipment/therapy.. I understand any further questions/problems should be called to the Company as soon as possible.

- | | | |
|--|--|---|
| <input type="checkbox"/> APP's | <input type="checkbox"/> Hospital Bed (809) | <input type="checkbox"/> Total Parenteral Nutrition |
| <input type="checkbox"/> Antibiotic Therapy (1304) | <input type="checkbox"/> Hydration Therapy | <input type="checkbox"/> Traction Equipment (817) |
| <input type="checkbox"/> Apnea Monitor (824) | <input type="checkbox"/> Hydraulic Lift (810) | <input type="checkbox"/> Trapeze Bar (8 11) |
| <input type="checkbox"/> Blood Glucose Monitor (818) | <input type="checkbox"/> IPPB (911) | <input type="checkbox"/> Ventilator (909) |
| <input type="checkbox"/> Breast Pump (8 19) | <input type="checkbox"/> Liquid Oxygen (907) | <input type="checkbox"/> Walk-aids (813) |
| <input type="checkbox"/> Bi-Pap | <input type="checkbox"/> Nebulizer (9 12) | <input type="checkbox"/> Wheelchair (808) |
| <input type="checkbox"/> C-PAP (915) | <input type="checkbox"/> Oxygen Concentrator (906) | <input type="checkbox"/> Phototherapy (823) |
| <input type="checkbox"/> Commodes & Related (812) | <input type="checkbox"/> Pain Management (1305) | <input type="checkbox"/> Oxygen Cylinders (904) |
| <input type="checkbox"/> Enteral Feeding (82 1) | <input type="checkbox"/> Pentamidine (9 14) | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Suction Pumps (8 15) | |
| | <input type="checkbox"/> TENS Unit (822) | |

I have received the patient information packet and understand my estimated cost is \$ _____ per _____ I also understand it is the company's policy to follow physician orders regarding life sustaining treatment.

For Infusion: I have been offered counseling on all new prescription medications by the pharmacist and understand I can call the pharmacist at the telephone number provided on the prescription label.

For Infusion, Clinical Respiratory, and Home Health Patients: I understand I have the right to formulate a living will. I have not named a surrogate decision maker regarding my health care.

Decision Maker's Name: _____ Address: _____
Phone # _____

Home environment is suitable for prescribed service Yes No
If no, recommended corrective action _____

Patient/family level of understanding: _____
Patient's goals related to therapy: _____

I authorize The Company to release records for the purpose of obtaining payment or medical treatment. Such records may be released to any agency or individual authorized to receive such information. I understand I have the right to refuse to release The Company records and that signing this consent constitutes a waiver of the right for a period of 2 years. I request that payment of authorized benefits be made on my behalf to The Company.

CONSENT FOR TREATMENT: I hereby authorize The Company staff to deliver/teach/administer/perfor that which has been prescribed by my physician.

