HUMENSIA
Avec vous, préservons l'essentiel

PATIENT CONSENT
HOME HOSPITALIZATION (HAD)

Mr, Mrs, Last Name : .....First Name :.....
Date of birth : .....
Address :.....
.....

Sir, Madam,

You are about to receive care through Home Hospitalization (HAD).

The duration of your care will be regularly reassessed by the HAD team.

Information regarding your care is detailed in the Patient Welcome Booklet, which has been provided to you.

☐ **Patient is able to express their will ;**

☐ ***Patient is a minor, under legal protection, or unable to express their will ;***

Acting as legal representative / point of contact

Name (Laste, First)

.....

.....

Relationship to the patient

.....

I hereby accept the terms and conditions of care provided by the Home Hospitalization service managed by HUMENSIA.

I authorize HUMENSIA healthcare professionals to access my Shared Medical Record (Dossier Médical Partagé – DMP).

Thir form is completed in two copies* in ....., on .....

Signature :

* *One copy is given to the patient, the other is kept by the HAD team.*

25, rue Michel Colombe - BP 72974 - 37029 Tours Cedex 1 - Tél. 02 47 36 29 29 - Fax. 02 47 70 42 49
humensia.org - contact@humensia.org
SIREN 775 348 501 - Membre du réseau UNA
Association à but non lucratif engagée pour la santé, les soins et l'accompagnement à domicile depuis 1955