

PAC ID NO:.....

SURNAME:.....

**INNER SOUTH EAST POST ACUTE CARE PROGRAM
CLIENT AGREEMENT**

NAME OF CLIENT

ADDRESS.....
.....

I agree :-

- To participate in the Inner South East Post Acute Care program
- The services provided will be in accordance with the agreed care plan
- I am aware that relevant information about my medical condition may be passed onto agencies providing assistance
- My local doctor will receive a letter outlining the services
- Information with all names and addresses removed can be forwarded to the Department of Human Services for the purpose of monitoring and evaluating the program

Signed (client)

Witness.....

Date

CARER CONSENT

If the client is unable to give informed consent a carer may sign on his/her behalf.

SIGNED (carer) Date.....

RELATIONSHIP.....

VERBAL CONSENT

If the client has been discharged prior to signing the ISEPAC Consent or unable to sign due to medical condition.

I
(staff member's name – please print)

of
(ward/department and hospital or ISEPAC Co-ordinator)

have spoken to
(client name)

and have explained the agreement form. I believe he/she understands as above.

Signed: (staff member)

Date: