Patient Rights

Within our capacity and scope of our mission and services, Regional Medical Center at Memphis respects and supports the patient's rights to impartial access to treatment and services that are consistent with relevant laws and regulations and medically indicated regardless of race, creed, sex or sexual orientation, national origin, age, disability, diagnosis or sources of payment.

As part of our teaching mission, resident and students may participate in your care along with you attending physician, registered nurses and other caregivers. Please speak with you nurse or doctor if you have any concerns.

We respect each patient's rights, dignity, values and spiritual, cultural, and personal needs. Because you are a partner in your healthcare, we want you to know your rights as well as your responsibilities during your hospital stay. We encourage you to join us an active member of your care team.

You, the patient, have the right to:

- Respectful care in a safe environment.
- An environment that is free from all forms of abuse, neglect, or mistreatment.
- Receive appropriate pain management.
- Obtain full information in layman's terms concerning your diagnosis, treatment and progress.
- Communication you can understand. Interpreter services and TDD phones are provided at no cost to you.
- Be informed of unexpected or unanticipated events.
- Know the identity of and professional status of individuals, doctors and other healthcare providers, involved in your care, and to know which physician or other practitioner is primarily responsible for your care. Regional Medical Center at Memphis is a teaching site for the University of Tennessee Health Science Center (UTHCS - Memphis). If you do not have a private doctor, you will be assigned to a healthcare provider who is on the faculty at UTHSC-Memphis, and/or a member of the medical clinical staff at the MED.
- Help plan your care and do your part of the plan.
- Have a surrogate decision maker take part in medical decisions.
- Choose visitors, even if they are not legal family members. You can withdraw consent or deny visitors at any time.
- Have access to a support person of your choosing at any time.
- To make decisions concerning your care, including advance medical directive such as a living will, durable power of attorney for healthcare, advance care plan or refusal of care. Should you be unable to make these decisions, you may appoint a surrogate to act on your behalf.

You, the patient, have the right to (continued):

- To express personal, spiritual and cultural beliefs and have your religious or other spiritual needs accommodated provided they do not interfere with others or the hospital operations. Chaplaincy services are available 24/7. You can ask the staff to contact a chaplain or request a clergy visit by calling 545-7925.
- Be free from restraints or seclusion that is not medically required.
- Respect for your privacy. You may give or refuse consent for recordings, photographs, films or other images used for internal or external purposes. Consents for recordings, photographs, films or other images may be withdrawn at anytime.
- Have your medical records and discussions regarding your care kept private, unless you tell us to share information regarding your condition and treatment.
- Receive detailed information about hospital and physician charges.
- Look at your written medical record with a doctor.
- Agree or refuse to participate in research studies. You may withdraw from a study at any time.
- Talk about an ethical issue with the Ethics Committee representative. To reach a member, you may page him/her at 790-9651.
- Voice your concerns about your care to a doctor, nurse manager, patient advocate, or any staff or contact:
    - A Patient Advocate by calling 545-7123;
    - The Joint Commission by calling 1-800-994-6610; via email at: complaint@jointcommission.org or by mail to: One Renaissance Boulevard, Oakbrook Terrace, IL 60181;
    - State of Tennessee Department of Health Complaint Line at (800) 852-2187; or
    - Medicare beneficiaries can contact 1-800-MEDICARE with a concern about the quality of care received.

You, the patient, have the responsibility to:

- To provide, to the best of your knowledge, accurate and complete past health information.
- Ask questions if you do not understand something that you have been told about your condition and treatment plan.
- Tell us when you see changes in your health condition.
- Provide a copy of your advance medical directive.
- Tell us if you feel unsafe or you are not happy with your care.
- Respect the rights of other patients, families and staff.
- Let us know if you have any personal, cultural, spiritual or other needs.
- Follow the hospital rules.
- Pay your bill on time.

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and <u>either</u> witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

<u>Agent</u>: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____
Address: _____

<u>Alternate Agent</u>: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

<u>Quality of Life</u>:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions **(you can check as many of these items as you want)**:

- ☐ **<u>Permanent Unconscious Condition</u>:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ☐ **<u>Permanent Confusion</u>:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ☐ **<u>Dependent in all Activities of Daily Living</u>:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ☐ **<u>End-Stage Illnesses</u>:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

<u>Treatment</u>:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

☐ ☐ Yes No	**<u>CPR (Cardiopulmonary Resuscitation):</u>** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ ☐ Yes No	**<u>Life Support / Other Artificial Support:</u>** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ ☐ Yes No	**<u>Treatment of New Conditions:</u>** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ ☐ Yes No	**<u>Tube feeding/IV fluids:</u>** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

<u>PLEASE SIGN ON PAGE 2</u>

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

_____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.