Hamilton Niagara Haldimand Brant (HNHB)
Regional Complex Care (CC) Program

Letter of Understanding about Complex Care

Recently, you (or your family member) and the health care team discussed your current health care needs. The choices of care available were discussed and we agreed your care needs may be best met within the regional Complex Care Program.

A referral will be made by your health care team to the HNHB Community Care Access Centre (CCAC). From there, your care needs will be reviewed to see if they can be met by the Regional Complex Care Program. If your care needs can be met, your name will be added to the wait list for a Complex Care bed within our region.

Regional complex care beds are located at these partnering hospital sites:

A group:	Hamilton Health Sciences - St. Peter's Hospital, Hamilton Joseph Brant Hospital, Burlington St. Joseph's Healthcare Hamilton
B group:	Niagara Health System – Welland Hospital, Greater Niagara General, Niagara Falls, Douglas Memorial, Fort Erie, Port Colborne General Hotel Dieu Shaver Health and Rehabilitation Centre West Lincoln Memorial Hospital, Grimsby
C group:	Brant Community Healthcare System Norfolk General Hospital, Simcoe
D group:	Haldimand War Memorial Hospital, Dunnville A group or B group depending on patient's address
E group:	West Haldimand General Hospital, Hagersville C or D group depending on patient's address

When the first available Complex Care bed becomes available, and you are the next on the waiting list in your hospital sites, your personal and medical information will be sent to the Complex Care Program for their review. You will then be notified when the bed is available. The hospital will arrange your move to the Complex Care bed in your hospital sites.

If you require a bariatric, ventilator or dialysis bed you will be admitted to the next most appropriate bed anywhere in the LHIN.

Once in Complex Care, the health care team will support your care needs and make plans for you to return home or to the next level of care when necessary. Please ask us any questions regarding this change to your care. We want to help you understand the next steps.

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I understand the above information and
Agree to proceed with a Complex
Care process.

Year / Month / Day	Printed Name of Patient or Substitute Decision Maker	Signature of Patient or Substitute Decision Maker

Staff – Printed Name	Staff – Signature and Designation

_____ I have received the Co-payment Information from _____
(Patient's Initials) (Print Name of Staff Member)

(Provide patient with a copy of this agreement upon completion)

Substitute Decision Maker Identification

Name: _____

Address & Phone #: _____

_____

Relationship to Patient: _____

1. I am at least 16 years old or I am under 16 years and the parent of the incapable patient
2. I believe that the incapable patient, when capable, would not have objected to me deciding about the proposed treatment.
3. I believe that no one ranking higher than me, or the same rank as me, claims authority and is available and willing to decide about the proposed treatment.

Choose one of the following:

a) Court Appointed Guardian
b) Power of Attorney
c) Representative appointed by the Consent Capacity Board
d) Spouse or Partner
e) Parent of Child
f) Parent with a right of access
g) Brother or sister
h) Any other relative related by blood, marriage or adoption.

Date (yyyy/mm/dd)_____ Signature of Substitute Decision Maker _____

Statement by Interpreter

I declare that I have accurately translated this form for the Patient/Substitute Decision Maker referred to below and translated the discussion between _____ and _____
(Name and Designation of Health Practitioner) (Name of patient / Substitute Decision Maker)

who understands the information given.

Date (yyyy/mm/dd)	Signature of Interpreter	Printed name of Interpreter	(___)_____ Phone Number