Welcome to Logansport Memorial Hospital

On behalf of our physicians, staff and volunteers, we welcome you to Logansport Memorial Hospital. We are dedicated to providing extraordinary patient care that is the most advanced and compassionate available, with physicians and staff who are highly trained and nursing care that is skillful and focused on the needs of the whole patient.

We are pleased to have the opportunity to care for you and your family. Your experience with our hospital is extremely important to us, and we value your comments. We want to ensure we are meeting all your needs during your hospital stay.

After your discharge, you may receive a patient satisfaction survey in the mail. We hope that you will take the time to complete the survey and share your thoughts.

Having peace of mind is an integral part of achieving and maintaining health. We hope the contents of this Patient Admission Guide, along with the knowledge that we are working around the clock to provide you with excellent service, will help you during your stay at Logansport Memorial Hospital.

Sincerely,

David Ameen
President/CEO
Your Safety Is Our Concern

You can help prevent errors in your care

Everyone has a role in making healthcare safe. That includes doctors, healthcare executives, nurses and healthcare technicians. As a patient, you can make your care safer by being an active, involved and informed member of your healthcare team.

• Speak up if you have questions or concerns. If you still don’t understand, ask again. It’s your body and you have a right to know.

• Pay attention to the care you get. Always make sure you’re getting the right treatments and medicines by the right healthcare professionals. Don’t assume anything.

• Educate yourself about your illness. Learn about the medical tests you get and your treatment plan.

• Ask a trusted family member or friend to be your advocate (advisor or supporter).

• Know what medicines you take and why you take them. Medicine errors are the most common healthcare mistakes.

• Participate in all decisions about your treatment. You are the center of the healthcare team.

Hospital identification

Logansport Memorial Hospital cares about your safety. We wear hospital identification so you can know who is taking care of you. If we forget to tell you who we are and what we do, ask us. It is important that you understand what is being done to help you get well. If you don’t know why you are getting tests, treatments, or medicine, ask your nurse.

If something about your care seems unusual, please ask to speak with the charge nurse. We welcome your questions.

Smoking

For health and safety reasons, Logansport Memorial Hospital is smoke-free. This means you and your visitors cannot smoke anywhere in the building, on the grounds or on the sidewalk. If you are a patient, ask your doctor or nurse for nicotine replacement products if you need them. If you would like information or help to quit smoking, please ask a respiratory therapist or a nurse. See page 7 in this packet for further information about how to quit smoking.
Preventing Infections

Infections are not caused by dirt, but by “bugs” or germs that live around us. The germs cannot be seen and sometimes live on your skin, in your mouths or in your nose.

Usually, these germs don’t make you sick, but when you are in the hospital, your body is weak and may not be able to fight off the “bugs.”

Wearing foot protection when you walk in your room or the hallway is one way you can stay free from germs.

Getting an infection while you are in the hospital could mean staying longer while it’s treated. We want to keep you from getting infections in the first place.

Your safety really matters to us.

Handwashing is the most important way to stop the spread of infection.

Because our staff wants to keep you as safe and healthy as possible, we take hand hygiene very seriously. If you’re worried that we might have forgotten to wash our hands, it’s okay to remind us. We will remind you and loved ones as well.

Handwashing tips for staff and visitors

- Use soap and water to wash your hands. Scrub them for 15 seconds. Rinse and dry.
- Wash your hands after going to the bathroom.
- Wash your hands before touching the patient or the patient’s belongings.
- Wash your hands before putting on gowns, gloves and masks or other isolation items.
- Wash your hands before making or offering the patient food.
- Wash your hands after helping the patient with toileting needs or changing diapers.
- Wash your hands before leaving the patient’s room.
- Do not touch other patients or their belongings (i.e. blankets, toys or clothing). They may carry germs.

Respiratory

Getting a respiratory illness can cause serious problems for patients in the hospital. Things you can do to keep from getting a respiratory illness are:

- Cough into a tissue or your shirt sleeve. Do not cover your mouth with your bare hands.
- Wash your hands often with soap and water or alcohol-based cleaner.

Other safety measures

Germs spread. To keep others from getting sick, you may be put in isolation. Certain things will be done to protect you and others. A sign will be posted outside your room. It tells people what they need to do before coming in and when leaving your room.
Improving Patient Care

Our staff continually focuses on ways to improve patient care and safety. Two important measures help us anticipate your personal needs and monitor your well-being:

Hourly Rounding

Purposeful hourly rounding helps us provide good care at your bedside. We get feedback from you about your condition and learn how we can meet your needs.

During these visits, our staff will:

• Check on you and your well-being.
• Monitor your comfort and pain.
• Help you move and change positions.
• Assist with trips to the bathroom for safety.
• Ensure you have access to the telephone, bedside table, water, call light, etc.

Why do you have pain?

When you are hurt or sick, it is common to have pain or discomfort, which can have many causes. Sometimes you have pain at the place of your injury or illness. Other times, you have pain in a different area of your body.

What is pain?

Pain is an uncomfortable feeling and is your body’s way of sending a warning to your brain. Each person’s pain is different.

How is pain treated?

Both medication and non-medication treatments can help in preventing and controlling pain. You and your healthcare team will decide which ones are right for you to get the greatest relief possible.

We encourage you to evaluate the visit. Did we...

• Greet you by name when we entered the room?
• Introduce ourselves to you?
• Keep you informed of your care plan?
• Meet your needs?
• Ask if you needed anything else?

Message Boards

To keep you and family members aware, the message board in each room lists the important goals for the plan of care. The message board:

• Identifies the caregivers.
• Defines the plan of care.
• Includes personal information important to you.
• Lists daily goals, such as deep breathing exercises, number of walks in the hallway, and the times of tests and procedures.

Pain Management

Medications

Your doctor may prescribe pain medications. There are many types of pain medicine. Your nurse will tell you about the specific medicine you are taking. If you have questions, be sure to ask your nurse, pharmacist or doctor.

Tell your doctor about all the medicines you are taking, including vitamins, supplements and herbs. This helps your doctor prescribe the right medicines for you to prevent drug interactions.
Pain Management

What is your role in pain management?

If your pain medicine does not help your pain, tell your nurse, pharmacist or doctor. Another kind of pain medicine may work better for you. If your medicine is causing you problems, let your doctor, pharmacist or nurse know. The amount you take or how often you take it may need to be changed.

Often doctors order pain medicine to be given “as needed.” This means you must tell the nurse when you need pain medicine. Try to ask for the medicine as soon as you begin to have pain. Do not wait until the pain is bad. The worse your pain gets, the harder it is to control.

Addiction

Sometimes patients worry about becoming addicted to pain medicine. In the hospital, the nurses and doctors will watch your use of pain medicine closely. Addiction is rare when pain medicine is taken as directed and for a short time.

If you are at risk for addiction or have been treated for it in the past, please tell your doctor or nurse.

Pain Scales

Several tools are available to help measure your pain. You will be asked to rate, describe and locate your pain. You will also be asked to determine a comfort or function goal, which is the level of pain you feel is tolerable to perform your activities of daily living.

Other ways to treat pain

Some things other than medicine may help your pain. You may try:

- Changing positions.
- Positioning pillows for comfort.
- Exercising your arms and legs. (Check with your nurse or doctor before trying this.)
- Walking.
- Sleeping.
- Listening to your favorite music.
- Watching TV or a movie.
- Talking with a friend.
- Using a waffle mattress (helps keep pressure off the bony places of your body).
- Using moist heating pads: usually for muscle pain. (Check with the nurse before using. Never place a heating pad directly over a medicine patch.)
- Using ice packs: usually for pain with swelling. (Check with the nurse before using.)
- Meditation.
- Massage.
- Guided imagery (mental pictures to help relaxation, concentration or pain relief.)
- Dimming the lights.
- Decreasing noise.

Questions for my healthcare provider

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Telemetry Monitoring

A telemetry transmitter will be used to monitor your heart’s electrical activity. Wires from electrodes attached to your skin will be connected to a small battery-operated radio transmitter than can be worn on your gown. This transmitter sends electrical signals to a receiver in the Intensive Care Unit (ICU) by way of a radio beam.

Your heart pattern will be watched by the ICU nursing staff, but your personal care will be given by the nursing staff in your area. In order to assist with your care while you are on telemetry, please read the following guidelines for activity. The nursing staff will be available to answer any questions you may have about these guidelines:

1. Report chest pain, shortness of breath, sweating, nausea, vomiting or dizziness to the staff immediately.
2. Be sure to take only medications administered by your nurse.
3. Stop activity and call for staff if pain develops during any activity.
4. Report loose wires to the staff.
5. Check with the staff before bathing. You will not be able to remove the transmitter to shower.
6. Avoid straining when having a bowel movement.
7. Avoid dropping, bumping or getting moisture on the telemetry transmitter.
8. When going to the bathroom, leave the door unlocked.
9. Rest after each meal and activity.

Pediatric Care

At Logansport Memorial Hospital, we want to give you the best and safest medical care possible. We care about keeping your child safe here in the hospital. As a parent, guardian or family member, you are an important part of your child’s healthcare team. You can help. Here are some things you can do to keep your child safe.

In the hospital

• A family-appointed individual age 18 or older needs to be with your child at all times.
• A cot is available upon your request.
• The hospital will provide breakfast, lunch and dinner for the individual designated to stay with your child. To take advantage of this service, please call extension 3663 between the hours of 6:30 am – 5:30 pm to order your meals.
• All patient rooms are private, with plenty of space for family to stay. No child wants to be sick. And certainly no parent wants his or her child to be hospitalized, but families may be comforted knowing we have pediatricians on call 24 hours per day.

Speak up for your child’s safety

• Be sure your child is wearing an ID band. Staff should check your child’s name before doing anything.
• Know who each staff person is and what they are there to do.
• Know the name and purpose of all of your child’s medicines.
• Ask all workers who have direct contact with your child if they have washed their hands.
• Know why tests are being done on your child.
• Write down important information about your child’s medical care. Blank pages are available in the back of this Admission Packet.
• Always ask questions if there is anything about your child’s care you do not understand.
You Can Quit Smoking!

Did you know?

- Cigarette smoking kills more than 430,000 Americans each year—more than the combined deaths from car crashes, fires, homicides, suicides, drugs, alcohol, AIDS.
- More than 10,300 deaths annually are related to smoking in Indiana.
- Smoking in pregnant mothers increases risk factors for low birth weight infants, infant mortality and long-term health outcomes of surviving infants.
- Cigarette smoking increases the risk of many forms of cancer.
- Cigarette smoking increases the risk of cardiovascular death by more than 5 times.
- After one heart attack, the risk of another is 22 - 47% higher if you continue to smoke.

STEP 1: Get Ready to Quit Smoking

Make a positive decision to quit. Set a target date for quitting and have realistic expectations. Expect to encounter stressful situations. Involve a friend or family member.

STEP 2: Change Your Habits

Disassociate smoking from driving, eating, etc. Try cutting down on the number of cigarettes you smoke and switching to a brand that does not taste as good to you.

STEP 3: Do a Trial Run

Practice going without cigarettes and clean your clothes to rid the smell of smoke.

STEP 4: Time to Quit!

- Throw away all your cigarettes.
- Have your teeth cleaned.
- Keep very busy.
- Remind your family friends.
- Buy yourself a treat or do something to celebrate.

STEP 5: Ease through the First Days

- Surround yourself with a clean, fresh, nonsmoking environment.
- Spend as much time as you can in smoke-free places.
- Drink large quantities of water or some fruit juice.
- If you miss the sensation of having a cigarette in your hand, hold something else: a pencil, a toothpick or a fake cigarette.
- Avoid temptation: brush your teeth after meals; take a walk.
- When the craving for a cigarette is overwhelming, substitute carrots, apples, raisins or sugarless gum. Cravings will go away in 2 – 5 minutes.
- Find new habits and activities – swimming, jogging, playing tennis, crossword puzzles, needlework or gardening.

What to Expect When You Quit Smoking

Your heart and lungs will begin to repair. Your sense of taste and smell may improve. You will breathe more easily, and your smoker’s cough may begin to disappear.

Temporary Withdrawal Symptoms

Your may experience temporary symptoms such as dry mouth or sore throat, headaches, trouble sleeping, irregularity (constipation or diarrhea), fatigue, excess hunger, tenseness and irritability or a cough.

Call the Indiana Tobacco Quitline for help!

You will receive one-on-one proactive telephone counseling to develop a plan to improve your chances of success. The Quit Coach will discuss medications, coping with cravings, avoiding weight gain and changing daily activities that trigger smoking. You’ll have access to 24-hour web coaching and receive referrals to local services in your community.

Indiana’s Tobacco Quitline is FREE, confidential and available 7 days a week, 24 hours a day, in 170 languages.

Indiana’s Tobacco Quitline
800-QUIT NOW (800-784-8669)
www.indianatobaccoquitline.net
Grateful Patients

Every year thousands of patients come to Logansport Memorial Hospital for treatment, but even the most remarkable success stories usually go untold. The Logansport Memorial Hospital Foundation is proud to reveal the Grateful Patients Series. It provides an opportunity for patients, clients, families and friends to say “Thank You” to the physicians, nurses, therapists and other members of the Logansport Memorial Hospital health care team who have made a memorable contribution to their patients’ health and well-being.

With the Logansport Memorial Hospital Foundation Grateful Patient Series, those interested in sharing their stories of healing will be featured in framed shadow boxes placed throughout Logansport Memorial Hospital.

Those interested in sharing their success stories are urged to contact the Logansport Memorial Hospital Foundation at 574.753.1595.

Donations

There are a number of ways you can give to the Logansport Memorial Hospital Foundation. Your giving goes to the area you choose and is essential to promoting good health in our communities.

- Restricted gifts are assigned to accounts consistent with donor wishes to be used by that program only.
- Unrestricted gifts are placed into the Foundation general account to be used as directed by the Foundation Board according to the strategic plan.
- Endowed gifts are placed in investment accounts. Only the interest from these accounts is used and the principal remains preserved.

Ways to give

You may give in several ways. There are advantages to each type of gift. Take some time to consider your options. You can make an immediate impact by making a gift today:

- Make an online gift with your credit card at www.logansportmemorial.org. Click on DONATE NOW.
- Make a credit card gift by phone: call 574.753.1595.
- Make a cash or credit card gift by mail by sending your cash gift or credit card information to:

Logansport Memorial Hospital Foundation
1101 Michigan Avenue
Logansport, IN 46947

Make checks payable to the Logansport Memorial Hospital Foundation.

Recognition

The Tree of Life is displayed in the Medical Office Building East. Donors may purchase a leaf for $250. The leaves are inscribed. All of the Tree of Life proceeds go to the Logansport Memorial Hospital Foundation general fund. Recognition is applicable to individual and corporate donors. Donors who wish to remain anonymous may do so.
Logansport Memorial Hospital provides financial counselors who are dedicated to assisting you with your financial concerns or questions. Our financial team can help with:

- Understanding your bills.
- Explaining what you can expect during the billing process.
- Accepting payment.
- Applying for financial assistance, if needed.
- Updating your insurance or payor information.

**Billing Insurance**

As a courtesy to our patients, LMH submits bills to your insurance company and will do everything possible to advance your claim. However, it may become necessary for you to contact your insurance company to give more information for claims processing requirements or to speed up payment. You should remember that your policy is a contract between you and your insurance company. You have the final responsibility for payment of your hospital bill.

**Physician Billing**

If you have been treated at LMH, you may receive several bills for medical care. Your hospital bill does not include the fees of your physician(s) or consulting physician(s). Fees for professional services rendered to you by radiologists, pathologists, surgeons, emergency room and ambulance are also not included on your hospital bill. Fees for these professional services are billed directly by the physicians or organizations providing services.

**Financial Arrangements**

For the financial health of the hospital, financial arrangement for payment is required at the time of service. Depending on your insurance benefits, the amount collected at your visit may be based on estimated charges. We will require payment for the part of your hospital service or physician bills not covered by your insurance plan. This may include co-payments and/or co-insurance amounts.

To assist you in meeting your payment obligations, LMH has the following payment options:

- Cash, checks, money orders.
- Debit or credit cards, including VISA, Master Card, and Discover.
- Online payment – it’s easy, secure and convenient.

**Timely Payment**

For patients with the ability to pay their bills, it is the obligation of the patient to pay the hospital in a timely manner. LMH makes every effort to see that patient accounts are properly billed and patients may expect to receive a uniform summary statement after discharge from an inpatient stay, outpatient visit or Logansport Memorial Physician Network visit. It is your responsibility to provide the correct insurance information.

If you do not have health insurance coverage and cannot afford to pay the bill in full, please contact a Financial Counselor.

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**FINANCIAL SERVICES CONTACT INFORMATION**

For more information about your bill  
574.753.1752  
8 am - 4:30 pm, Monday - Friday

Financial Counselors  
574.753.1371 or 574.753.1577  
7 am - 5:30 pm, Monday - Friday

By Mail  
Patient Accounts  
Logansport Memorial Hospital  
1101 Michigan Avenue  
Logansport, IN 46947

www.logansportmemorial.org
Planning for Discharge

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver (family member or friend) are important members of the planning team. Below you’ll find information on the discharge process at Logansport Memorial Hospital. Please do not hesitate to ask us any questions regarding your discharge.

If you have any questions, be sure to ask! We are happy to answer any question you may have about your discharge, the discharge process and caring for yourself at home. The more thorough our discharge process, the more likely you are to have a healthy recovery.

The discharge process begins at admission

Throughout your hospitalization a member of our staff will go over your plan of care with you, talk to you about follow-up appointments, and explain the discharge procedure. You will be provided with specific verbal and written instructions about your plan of care regarding:

• Your discharge location—Home or another care facility (rehabilitation hospital or nursing home, for example).
• Activity—Bathing, dressing, climbing stairs, cooking, shopping, driving, etc.
• Medications—We will go over your list of medications including all prescription and non-prescription drugs, vitamins and supplements.
• Equipment—Extra equipment you might need at home (wheelchair, oxygen, hospital bed, shower chair, etc.).
• Pain management—We will discuss the best ways to manage your pain after discharge.
• Diet—We will go over any limitations to your diet.
• Follow-up care as directed by your physician.
• Home care services—Your physician or our staff can help you choose a company that can provide the required services or equipment.

Leaving your room

Before leaving your hospital room, please be sure that you have the following:

• Written discharge instructions.
• Prescriptions that need to be filled.
• All of your personal belongings – check all the drawers, closets, bathroom, etc.
• Any necessary supplies (gloves, lotions, pads, etc.) that may have been given to you during your stay.
• Any flowers or gifts sent to you.

For additional assistance with your discharge planning needs, contact a Case Manager at 574-753-1552. If no answer, please leave a confidential voice mail message.
After Discharge

Filling prescriptions

When you are discharged, you may fill prescriptions at Community Pharmacy in the hospital lobby. Community Pharmacy is open from 8:30 am to 5:30 pm Monday through Friday. Filled prescriptions may be delivered to you in the hospital or anywhere in Logansport free of charge. The phone number is 574.732.0418 or 800.793.7455.

When to call your doctor

Notify your physician if you have any concerns, or if you develop any of the following:

• Any sign of infection.
• A fever greater than 101 degrees, or chilling.
• A foul odor or foul drainage from a surgical site.
• Redness or excessive swelling.
• Persistent nausea or vomiting.
• Persistent diarrhea or constipation.
• Excessive bleeding.
• Excessive pain (including severe headache)
• Respiratory problems.
• Difficulty with urination.
• Any unusual symptoms noted through education during your hospital stay and discharge.

Should you have an emergency upon arriving home, please do not call the hospital. Call 911 immediately!

Tell us about your visit

Everyone at Logansport Memorial Hospital is committed to providing the best possible care when you are a patient or visitor at our facility, and you can help us. When you receive the survey in the mail, please take a few moments to tell us about your recent visit to the hospital. We value your feedback because we want to provide a great experience for every patient. Your individual comments are confidential, but your response helps us improve existing services, recognize the people who are performing well, and provide new services for you and our community.

How to get your records

To receive a copy of your medical record or to have your medical record forwarded to a party other than yourself, an Authorization for Disclosure of Protected Health Information is required. Upon receipt of a signed Authorization form, Logansport Memorial Hospital will process your request and send an invoice for payment of copies. Authorizations are in the Medical Records Department.

MEDICAL RECORDS
CONTACT INFORMATION

Medical Records
574.753.1390
6 am – 5 pm, Monday – Thursday
6 am – 4:30 pm, Friday

By Mail
Medical Records
Logansport Memorial Hospital
1101 Michigan Avenue
Logansport, IN 46947

www.logansportmemorial.org
Need a Doctor or Nurse Practitioner?

Our team of physicians and allied healthcare providers at Logansport Memorial Hospital are dedicated to understanding the causes of disorders and injuries. Our doctors and staff provide the best medical and surgical care available with compassion and sensitivity to their patients’ needs.

Find-A-Doc

Our Find-a-Doc Service is for the convenience of area patients who are looking for a doctor or nurse practitioner. Simply call the number to be placed with a physician or nurse practitioner in the Logansport Memorial Physician Network.

**FIND A DOC**

574-725-3463

All providers

For a full list of providers at Logansport Memorial Hospital, pick up a brochure at the Information Desk in the lobby.

You may also search our website: www.logansportmemorial.org.

Click on the Find a Doctor tab for a listing by specialty, individual or practice name.

Walk-in clinics

You’re too sick to stay at home, but too well for the ER. Now what? ExpressMed is an extended healthcare service of Logansport Memorial Hospital designed to treat minor emergencies. The clinics are staffed by doctors, nurse practitioners, and nurses. No appointment is necessary.

ExpressMed Logansport

3400 East Market at Cass Plaza
Logansport, IN 46947
574.722.9633
Open 7 days a week
Limited hours on major holidays

ExpressMed Walton

110 South Main
Walton, IN 46799
574.626.2432
Open Monday - Friday
No Holidays

Camden Family Medicine

132 West Main
Camden, IN 46917
574.686.2022
Open Monday - Friday
No holidays
How to Tell if You Have an Emergency

Call 911 if you, or someone you are with, needs immediate medical treatment. To make this decision, ask yourself the following questions:

- Is the victim’s condition life-threatening?
- Could the victim’s condition worsen and become life threatening on the way to the hospital?
- Does the victim require the skills or equipment of paramedics or EMTs?
- Could the distance or traffic conditions cause a delay in getting the victim to the hospital?

If your answer to any of these questions is “yes,” or if you are unsure, it is best to call 911. When you call for help, speak calmly and clearly. Give your name, address and phone number, the location of the victim and describe the problem. Do not hang up until the operator tells you to, because he or she may need more information or need to give you instructions.

Paramedics and EMTs can begin medical treatment at the scene and on the way to the hospital and alert the emergency department of your condition enroute.

An Urgency?

See your doctor or go to ExpressMed.

- Asthma—mild to moderate
- Back pain
- Burns—moderate/second degree
- Coughing, severe sore throat
- Cuts, scrapes, bruises
- Ear pain
- Eye irritation
- Fever
- Flu
- Runny nose, sinus trouble
- Skin rashes, itch, sunburn
- Sore throat
- Sprains
- Urinary burning

Or Emergency?

Go to Logansport Memorial Hospital’s ER.

- Amputations or severe lacerations
- Breathing difficulty or obstruction
- Burns—severe/third-degree
- Drug overdose
- Facial or eye trauma
- Knife or gunshot wound
- Large or compound bone fractures
- Loss of consciousness
- Poisoning
- Pregnancy—severe abdominal pain
- Seizures/convulsions
- Shortness of breath/chest pain
- Suicide attempt
- Suspected heart attack or stroke
Spiritual Care

Hospital chaplains

Chaplains are members of the healthcare team who give emotional and spiritual care to patients, families and staff members. They offer acceptance and comfort during illness, injury and loss. Chaplains are available to listen, offer support and help people connect to their own spiritual resources.

Patients and families often ask for a Chaplain when:

• They want to express anxiety or fear.
• They want to confide in a safe person.
• Outcomes are uncertain and life seems out of control.
• They want the comfort of prayer, traditions and sacraments.
• They feel discouraged or depressed.
• Test results, procedures or surgeries bring bad news.
• They are concerned about a religious issue.
• They have concerns about purpose, personal/spiritual issues, values or broken relationships.
• They do not have supportive friends or family nearby.
• Their own clergy wants insights about hospital procedure or practices.
• The family wants to discuss organ donation.
• They wish to prepare an advance directive and have questions other staff cannot answer.

Ministries and services

• Notifying the patient’s faith community
• Grief support
• Listening
• Prayer
• Counseling
• Presence
• Worship
• Spiritual guidance
• Devotional material for reading

Chapels

Logansport Memorial Hospital offers two chapels for patients and visitors who need a quiet place for contemplation or prayer. Appropriate reading material that may help during stressful situations is found in each chapel.

• **Drew Walker Eckert Chapel**
  second floor across from the main elevators.

• **Memorial Hospital Chapel**
  off the ER Lobby

To speak with the Chaplain, please ask your nurse or call extension 1740 to leave a confidential message.
Visiting Hours & Communication

Visiting hours

It is important that patients receive as much rest as possible to enhance their recovery. Logansport Memorial Hospital encourages open visitation by family and friends as long as it is appropriate to the patient’s condition. All visitation is subject to limitation by the Patient Care Staff.

Cell Phones

Cell phones may be used in all common areas of the hospital including the cafeteria, lobby, conference rooms and administrative areas. Cell phones may be used in patient care areas unless otherwise indicated. You may be asked to place your phone on vibrate.

Please refrain from photographing hospital staff while care is being provided.

Remember privacy, courtesy and confidentiality when using your cell phone.

Wireless Internet access

Logansport Memorial Hospital is pleased to provide complimentary wireless Internet access for our guests and visitors. You may connect to the “LMH public Wiﬁ” for Internet access.

Television channels available

A listing of TV channels is inserted in the front cover of this packet.

Interpreter service

Logansport Memorial Hospital has Spanish interpreters available. Call 574.753.1556 or 574.753.1736.

Telephones

Telephones are provided in each room, except on the Intensive Care Unit. Patients may receive calls in their rooms.

- Local calls may be made at any time from the room by dialing 9 and then the number.
- All other calls may be made collect or charged to your telephone credit card by dialing 9.
- Long distance calls cannot be charged to your room.

Public telephones are located on the first floor in the main lobby next to the Cashier and on the second and third floors in the waiting areas.

Family and friends may call you in your room through the main hospital line, 574.753.7541, or by dialing the number on the phone at your bedside. A toll-free number is available for family members: 800.243.4512.

A Telecommunications Device for the Deaf (TDD) is available for incoming and outgoing calls. A direct line is available to the TDD from outside of the hospital—574.753.5672. A telephone amplification device is also available for the hearing impaired.
Food Services

Patient Meals

Wholesome, nourishing and well-balanced meals are an important part of your treatment and recovery. Patient meals are served through the Café Express menu from 6 am to 6 pm, but you must order by 5:30 pm. Because we want your meals to be enjoyable and nutritious, we offer a restaurant-style menu for you to choose from a variety of selections at a time convenient for you.

Cafeteria

Stop by for a meal or snack at the hospital cafeteria—Café Express—located on the lower level of the hospital. Café Express is open to the public and serves hot, nutritious meals for breakfast, lunch and dinner, and hosts a deli sandwich station and a salad bar. Join us for a free cup of coffee.

Café Express hours Monday through Friday are 6:30 am to 7 pm:
- Breakfast 6:30 am – 9:30 am
- Lunch 10:30 am – 1:30 pm
- Dinner 4:30 pm – 7 pm

Café Express hours Saturday and Sunday are 6:30 am to 2 pm:
- Breakfast 6:30 am – 9:30 am
- Lunch 10:30 am – 2 pm

Snacks and Cold Drinks

Snacks and cold drinks are available in several places in the hospital:
- Café Express – Lower Level
- Coffee Shop in the lobby – First Floor
- Drink vending machine – Second Floor
- Vending machines with credit/debit card access:
  - Across from the elevators - Lower Level
  - Near Emergency Room lobby – First Floor

Coffee Shop

The Coffee Shop is located in the main lobby. We proudly serve Starbucks coffee and drinks and offer a variety of pastries. VISA and Mastercard are accepted.

Hours: 6:30 am – 4 pm
Monday – Friday
Lobby Services & Parking

ATM/Banking

For your convenience, an ATM is available in the main lobby near The Coffee Shop.

Gift Shop

Located in the main lobby, the Gift Shop has a wide selection of gift items, jewelry, greeting cards, toiletries, magazines, books and flowers. The shop is staffed by volunteers of the Mary Dykeman Guild. Profits are used to purchase new equipment or fund various patient services at Logansport Memorial Hospital. Gift Shop hours:

Monday – Friday: 8:30 am - 6:30 pm
Saturday: 10 am - 4 pm

The Gift Shop phone number is 574.753.1503. Dial 1503 from your hospital room.

Parking

A Parking Deck gives ample parking for patients and visitors. This map will help familiarize you with the Logansport Memorial Hospital facilities, including entrances and handicap parking.

Community Pharmacy

The Community Pharmacy is located in the main lobby. For your convenience, you may purchase drugs and medication prescription upon your discharge. Community Pharmacy carries a variety of over-the-counter medications, first aid supplies and durable medical equipment. Flavor additives can make any medicine taste better, and free delivery in Logansport is available. Community Pharmacy offers e-prescribing and a safe med disposal program. Business hours are 8:30 am to 5:30 pm, Monday through Friday. The phone number is 732.0418 or 800.793.7455. Dial 1326 from your hospital room.

www.logansportmemorial.org
Patient Bill of Rights and Responsibilities

We want to encourage you, as a patient at Logansport Memorial Hospital, to speak openly with your health care team, participate in your treatment choice, and promote your own safety by being well informed and involved in your care. Because we want to work together with you, we want you to know your rights as well as your responsibilities during your stay with us. We ask you and your family to join us as active members of your care team.

Your Rights
You and/or your representative have the right to:

Adequate, appropriate, compassionate care.
• Receive considerate, respectful and compassionate care in a safe setting regardless of your financial responsibility, age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
• Personal privacy and to receive care in a safe setting free from all forms of abuse or harassment.
• Be called by your proper name and to be in an environment that maintains dignity.

Staff identification
• Be told the names and know the professional status of your doctors, nurses and all healthcare team members directing and/or providing your care and to know the reasons for any proposed change in the Professional Staff responsible for your care.
• Know the relationship(s) of the hospital to other persons or organizations participating in the provision of your care.

Information about your medical condition and healthcare
• Have a family member or person of your choice and your own physician notified promptly of your admission to the hospital.
• Expect Memorial Hospital to respect your rights for effective communication.
• Be informed of your health status and be involved in care planning and treatment.
• Make informed decisions regarding your care.
• Be told by your doctor about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes.

Pain management
• Have your pain assessed and to be involved in decisions about treating your pain as effectively as possible.

Refusal of treatment, research or experimental procedures
• Be able to request or refuse care, treatment and services in accordance with the law and regulations. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. If you leave the hospital against the advice of the doctor, the hospital and doctors will be not responsible for any medical consequences that may occur.
• Be fully informed of and to consent or refuse to participate in any unusual, experimental or research project without compromising your access to services.

Freedom from restraints
• Be free from restraints of any form that are not medically necessary or used as a means of coercion, discipline, convenience or retaliation by staff.

Medical records
• Access information contained in your clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.
• The right to confidentiality of your clinical records.

Visitation
• Be informed (or support person, where appropriate) of your visitation rights.
• Receive (subject to your consent, which can be withdrawn at any time) the visitors whom you designate, including but not limited to a spouse, a domestic partner (including same-sex domestic partner), another family member or friend.
• Not be restricted, limited, or otherwise denied visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
• Know that the type and number of visitors present may be reasonably restricted or limited by staff to the extent such restriction or limitation is clinically necessary and communicated by the health care providers to the patient (or your designated representative or decision maker).
• Know the hospital will ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

Continuity of care
• Participate in the development and implementation of your plan of care. You can expect to be told in a timely manner of the need for planning your discharge or transfer to another facility or level of care and to know the reasons why. Before your discharge, you can expect to receive information about follow-up care that you may need.
Information about your hospital bill
• Examine and receive explanation of your hospital bill regardless of the source of payment.
• Access the cost, itemized when possible, of services rendered within a reasonable period of time.
• Be informed of the source of the hospital’s reimbursement for your services, and of any limitations which may be placed upon your care.
• Receive information regarding your financial concerns by contacting the Financial Counselor at Extension 1577 or 1371.

Advance Directives
• Formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives. If you do not have an advance directive, we can provide you with information and help you to complete one.
• Have a surrogate (parent, legal guardian, person having medical power of attorney) exercise the patient’s rights when the patient is incapable of doing so, without coercion, discrimination, or retaliation.
• Provide for the process to inform each patient, or when appropriate, the patient’s representative (as allowed under state law) of the patient’s rights in advance of furnishing or discontinuing patient care whenever possible.
• To have issues related to care at the end of life addressed with sensitivity.
• Know that your family has the right of informed consent of donation of organs and tissues.

Spiritual care
• Express spiritual beliefs, cultural practices and pastoral services as long as these do not harm others or interfere with treatment or plan of care.
• Receive physical or spiritual support during times of illness and through the dying process.

Grievances
• Expect that you can freely voice complaints and recommend changes without being subject to coercion, discrimination reprisal, or unreasonable interruption of care, treatment or services.
• Expect prompt resolution of complaints and grievances by contacting the Patient Service Line at Extension 1383.
• Raise ethical issues concerning care, treatment or services with the care providers and/or with the hospital’s ethics committee by contacting the Patient Service Line at Extension 1383.
• Access the internal grievance process by calling the Patient Service Line at Extension 1383. Also you have the right to access an external agency by calling 800.246.8909, Indiana State Department of Health, 2 N. Meridian Street, Indianapolis, IN 46204.

Your Rights
You and/or your representative have the responsibility to:

Provide information
• Provide complete and accurate information including your full name, address, home telephone number, date of birth, social security number, insurance carrier and employer, when it is required.
• Provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
• Provide the hospital or your doctor with a copy of your advance directive if you have one.

Your care
• Participate in the development and implementation of your plan of care recommended by the physician and accept the consequences if you do not. You have the responsibility to keep appointments, be on time and call your health care provider if you cannot keep your appointments.
• Report unexpected changes or conditions to your physician.
• Ask questions when you do not understand information or instructions. If you believe you can’t follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment and services plan.
• Depend not just on your hospital care, but also on the decisions you make in your daily life. You are responsible for recognizing the effect of life-style on your personal health.

Treat others respectfully
• Show respect of the needs and property of other patients, staff, and the hospital. Please leave valuables at home and only bring necessary items for your hospital stay.
• Treat all hospital staff, other patients and visitors with courtesy and respect; abide by all hospital rules and safety regulations; and be mindful of noise levels, privacy and number of visitors.

Financial responsibility
• Pay your bills in a timely manner.
• Provide information for insurance claims and for working with the hospital to arrange payment.
• Contact the Financial Counselor at 574.753.1577 or 574.753.1371 if you have questions or need financial assistance with your medical bills.
HIPAA Notice of Privacy Practices

Effective Date: April 14, 2003
Revised Date: September 18, 2008

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact our Privacy/Corporate Compliance Officer at 574.753.1767.

Who will follow this notice?
This notice describes our hospital’s practices and that of:
• Any health care professional authorized to enter information into your hospital chart;
• All departments and units of the hospital;
• Any member of a volunteer group we allow to help you while you are in the hospital;
• All employees, staff and other hospital personnel; and
• Physician practices owned by Memorial Hospital.

Definition
Protected Health Information (PHI) – Is individually identifiable health information that is maintained or transmitted either electronically or in any other form or medium. PHI includes demographic information collected from an individual and is created or received by a health care provider, and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Our Pledge Regarding PHI
We understand that PHI about you and your health is personal. We are committed to protecting PHI about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor’s use and disclosure of your PHI created in the doctor’s office or clinic. This notice will tell you about the ways in which we may use and disclose PHI about you. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. We are required by law to:

• make sure that PHI that identifies you is kept private;
• give you this notice of our legal duties and privacy practices with respect to PHI about you; and
• follow the terms of the notice that is currently in effect.

How we may use and disclose PHI about you
The following categories describe different ways that we use and disclose PHI. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

• For Treatment. We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. We may disclose PHI about you to doctors from other hospitals when we are coordinating your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share PHI about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays. We also may disclose PHI about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as family members, clergy or others we use to provide services that are part of your care.

We may share PHI with you at the time of your treatment. You are responsible for protecting your PHI. Memorial Hospital and its staff will not be liable for any loss of the PHI shared with you.

• For Payment. We may use and disclose PHI about you so that the treatment and services you receive at the hospital may be billed for and payment may be collected from you, an insurance company or a third party. For example, we may need to give your insurance company information about surgery you received at the hospital so your insurance company will pay us or reimburse you for the surgery. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
HIPAA Notice of Privacy Practices

- **For Health Care Operations.** We may use and disclose PHI about you for hospital operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine PHI about many hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the PHI we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

- **Appointment Reminders.** We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

- **Treatment Alternatives.** We may use and disclose PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities.** Memorial Hospital Foundation of Cass County, Inc. may contact individuals in an effort to raise money for the hospital and its operations. If an individual does not want the foundation to contact them for fundraising efforts, the individual must notify the Foundation Director in writing.

- **Facility Directory.** We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don’t ask for you by name. This is so your family, friends, and clergy can visit you in the hospital.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release PHI about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients’ need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the hospital. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the hospital.

- **As Required By Law.** We will disclose PHI about you when required to do so by federal, state or local law.

**Special Situations**

- **Organ and Tissue Donation.** If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, foreign or domestic, we may release PHI about you as required by military command authorities.
• **Workers’ Compensation.** We may release PHI about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• **Public Health Risks.** We may disclose PHI about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law; and

• we may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

• **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

• **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena by someone else involved in the dispute, which requires a signed authorization by you.

• **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official as authorized by law:
  - in response to a court order, subpoena, or similar process; or
  - about a death we believe may be the result of criminal conduct.

• **Coroners, Medical Examiners and Funeral Directors.** We may release PHI to a coroner or medical examiner as authorized by law. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI about patients of the hospital to funeral directors as necessary to carry out their duties.

• **National Security and Intelligence Activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

• **Protective Services for the President and Others.** We may disclose PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

• **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your right regarding PHI about you

You have the following rights regarding PHI we maintain about you:

• **Right to Inspect and Copy.** You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to Medical Records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

• **Right to Amend.** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital. To request an amendment, your request must be made in writing and submitted to Medical Records. In addition, you must provide a reason that supports your request.
HIPAA Notice of Privacy Practices

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the PHI kept by or for the hospital;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of PHI about you. To request this list or accounting of disclosures, you must submit your request in writing to Medical Records. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.logansportmemorial.org. To obtain a paper copy of this notice, please visit any registration desk.

Changes to this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the hospital. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact our Privacy Officer by calling 574-753-1767 or toll free 1-877-780-9368, or by writing to Privacy Officer, Memorial Hospital, 1101 Michigan Avenue, Logansport, IN 46947. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

**Other uses of medical information**

Other uses and disclosure of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provided to you.
Advance Directives

What are Advance Directives?

Advance Directives are written directions that indicate the specific type of care an individual wishes to receive if they become physically or mentally unable to communicate their wishes concerning health care.

Memorial Hospital has two types of Advance Directives available on the following pages:

1. A Living Will—written instructions that express your wishes regarding health care should you be unable to verbally express your wishes.

2. Power of Attorney—A written document where you appoint someone you trust to make decisions about your medical treatment/health care and assist with your financial matters should you be unable to do so.

Here are some medical terms that may be useful for you to know before completing an Advance Directive.

CPR—Cardiopulmonary resuscitation—a technique used to restore or maintain breathing and/or heartbeat using chest compression, artificial ventilation, electrical shock and medications.

Mechanical Ventilator—A machine connected by tubing in the mouth, nose, or throat that is used to assist or keep a patient breathing. It pushes oxygen into the person’s lungs.

Artificial Nutrition—also known as artificial feeding/feeding tube—a patient is given nutrition through a tube inserted into the nose, mouth, vein or stomach because the individual is no longer capable of eating.

Artificial Hydration—Fluids are provided to the patient through a tube inserted into the nose, mouth, vein or stomach.

Dialysis—A machine that performs the functions of the kidneys when the individual’s kidneys are not working effectively. Dialysis is done several times a week and takes several hours a day.

Before choosing an advance directive, read the booklet in this packet entitled “Your Right to Decide.”
A Medical Directive/Living Will

Your choices on this form will help others make medical decisions for you only if you become unable to speak for yourself. This Medical Directive will serve you upon admission, unless otherwise stated. You can change these directions at any time, either verbally or by written instruction. Please provide copies for your family/proxy and doctor.

A) If I’m in a life-threatening situation with good chance for recovery, but can’t speak for myself, I make these choices:

- CPR
  - [ ] Yes
  - [ ] No. This means if my heart stops beating or if I stop breathing, no medical treatment will be started or continued.

- MECHANICAL VENTILATOR:
  - [ ] Do not intubate. I will not be placed on a breathing machine.
  - [ ] For a short time with re-evaluations.
  - [ ] For the rest of my life.

I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

- FEEDING TUBE:
  - [ ] For a short time with re-evaluations.
  - [ ] For the rest of my life.

- HYDRATION AND NUTRITION:
  - [ ] Yes
  - [ ] No

- DIALYSIS:
  - [ ] For a short time with re-evaluations.
  - [ ] For the rest of my life.

- COMFORT CARE ONLY:
  - [ ] Yes
  - [ ] No

Other Treatments:

B) If my physician certifies that (1) I have an incurable injury, disease, or illness; (2) My death will occur within a short time; and (3) The use of life-prolonging procedures will artificially prolong the dying process, I make these choices:

- CPR
  - [ ] Yes
  - [ ] No

- FEEDING TUBE
  - [ ] Yes
  - [ ] No

- DIALYSIS
  - [ ] Yes
  - [ ] No

Other Treatments:

C) I have a Directive, and it will be brought to the hospital to be put in my record.

Date received:

D) Yes  No

I want to make an anatomical gift of all or part of my body, subject to the following limitations:

Person(s) appointed to make medical decisions on my behalf:

Name: ____________________________  Name: ____________________________
Address: __________________________  Address: __________________________
Phone (H) _______ (W) _______ Phone (H) _______ (W) _______

I, being at least eighteen years of age, and of sound mind, willfully and voluntarily make known my desires.

If I am unable to speak for myself, I appoint ____________________________ to carry out the directions I have stated above as my final expression of my legal right to refuse or to receive medical treatment. I ask my family and doctor to abide by my wishes. I understand the full import of this declaration.

Signed ____________________________  Date ____________________________
Printed ____________________________  City/State ____________________________
Witness ____________________________  Witness ____________________________
Living Will Directions

Treatment Decisions

Complete in order by lettered sections.

A. This section is for the time when you are involved in a life-threatening situation with a good chance of recovery (example: you are in a motor vehicle accident and you have a good chance of recovery). What would you want done? Select the choices that are listed below that statement. You may reference the explanations for those choices on page 24. Complete all the answers unless you only want the Comfort Care Only choice. If you want that, please mark only that selection.

B. This section is for the time when your physician certifies in writing that your death will occur shortly, you have a terminal illness or putting you on machines would prolong the dying process (chances of recovery are not there). What would you want done? Select the choices that are listed below that statement. You may reference the explanations for those choices on page 24. Complete all the answers unless you only want the Comfort Care Only choice. If you want that, please mark only that selection.

C. On your original copy, mark the date that you delivered a copy to the Medical Records Department so that we have a record of your wishes whenever you become a patient at Logansport Memorial Hospital.

D. If you want to be an organ/tissue/eye donor, please indicate your desire to be a donor. There is space provided if there are any limitations to your donation if you request.

Medical Decision Appointee(s)

The next section is for you to appoint a person or persons to make medical decisions for you. If you choose only one person, cross off the second set of Name, Address and Phone lines and initial it.

The person or persons do not legally represent you. They speak in your behalf because they know what you want and are likely to carry out your wishes.

Signatures

The last section at the bottom of the Living Will is for the signature of you and two witnesses. The witnesses must be:

1. 18 years of age or older (No one under the age of 18 is allowed to complete a living will or be a witness).

2. Unrelated to you.

3. Not entitled to any part of your estate.

These two witnesses may be neighbors, friends, clergy or whoever is available. They are merely witnessing your signature.

This form is only as good as the paper it is written on. It is a tool for you to begin your discussion with your family regarding your choices. They do not have to agree with your decision. It is very important that you do discuss this with your family since they are likely to be the ones that will be discussing your care with your doctor. Once you have completed and discussed this information with your family, make copies of the Living Will. Whomever you distribute it to, please write that person’s name on the back of your original Living Will. That way if you ever need to change your Living Will, you will know who to contact for the corrections/additions or deletions.

Living Wills may be changed at any time, but should be reviewed every 5-10 years.

Should you have any questions, please feel free to contact one of the following people at Logansport Memorial Hospital:

- Chaplain
  574.753.1740

- Case Management Director
  574.753.1397
Power of Attorney

I, ____________________________ of the City of ________________, Indiana, County of ________________, do hereby designate ____________________________ of ________________, Indiana, my true and lawful attorney-in-fact, or agent, to have and to exercise the following powers, subject to the terms and provisions of IC 30-5-2-1 et seq.:

i. to make, draw, and endorse checks or bills of exchange and to waive demand, presentment, protest, notice of protest, and notice of non-payment of all such instruments;

ii. to receive and to demand all sums of money, debts, dues, accounts, bequests, interest, dividends, and demands whatsoever which are now or shall hereafter become due or payable to me and to compromise or discharge the same;

iii. to sell real estate, including my home;

iv. to have access to my safety deposit box;

v. to perform my banking and have access to all my bank accounts;

vi. to sell personal property;

vii. to file my federal and state tax returns and represent me before such governmental agencies;

viii. to make health care decisions.

I hereby reserve the right to revoke.

I hereby state, declare and represent further, in accordance with IC 30-5-2-1, that the Power of Attorney herein conferred by said, ____________________________, as principal, to the aforesaid ____________________________, as said attorney-in-fact, shall become effective upon the incapacitation, as defined pursuant to IC 29-3-1-7.5, of the principal designated herein, whether such incapacitation shall be attributable to insanity, mental illness, senility, infirmity, disappearance, physical or mental incapacity, or disability, or other incapacity, it being the express, deliberate and conscious objective and intent of the aforementioned designed attorney-in-fact notwithstanding later incompetence of the principal or later uncertainty as to whether the principal is dead or alive.

If for some reason a guardianship of my person or a conservatorship of my estate is deemed to be necessary, I hereby express my desire to have ____________________________ appointed as my guardian and/or conservator. In the event ____________________________ cannot or will not serve as my guardian, I appoint ____________________________ as my future guardian/conservator.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this __________ day of __________, 20 __________.

Principal

STATE OF INDIANA
) SS:
COUNTY OF CASS

Before me, a Notary Public in and for said County and State, personally appeared ____________________________, who acknowledged the execution of the foregoing Power of Attorney, and who, having been duly sworn, stated that any representations therein contained are true.

Witness my hand and Notarial Seal this __________ day of __________, 20 __________.

Notary Public

My Commission Expires: __________ County of Residence: __________
Power of Attorney Instructions

The **Power of Attorney** form is for those individuals who are requesting that someone be appointed to represent them when it comes to financial and healthcare decisions. Your attorney can also draw up a document for you that would be more specific to you and your needs/wants.

To complete this form, you are required to have a notary signature.

The blanks are completed in the following order:
- Your full name.
- Your city of residence.
- Your county of residence.
- The person you designate to be your Power of Attorney.
- The State where this person resides.
- Your name – you are the Principal.
- The Power of Attorney’s name – the person you appointed.

The last paragraph above IN WITNESS WHEREOF may be completed or left blank. If you are not planning to complete it, simply “X” it out and initial it. If you do plan to complete it, fill the blanks accordingly:
- The person you appoint as your guardian and/or conservator.
- The same person as you appoint.
- The person who you want in case the above person is not able to serve as your guardian (back up person).

The notary **MUST** witness your signature for it to be valid. Anyone receiving a copy of this should be listed on the back of the original. Most banking institutions as well as other businesses will want to have a copy of the original for validation purposes.

Should you have any questions, please feel free to contact one of the following people at Logansport Memorial Hospital:

**Case Manager’s Office**
574.753.1552

**Case Management Director**
574.753.1397
Valuables

You are urged to leave valuables at home. Other than the personal property listed below, please send all belongings home, including jewelry, cell phones, cash, wallets, purses, etc.

<table>
<thead>
<tr>
<th>PATIENT PERSONAL PROPERTY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentures, Upper, Full or Partial</td>
<td>Hearing Aid, Right</td>
</tr>
<tr>
<td>Denture, Lower, Full or Partial</td>
<td>Hearing Aid, Left</td>
</tr>
<tr>
<td>Glasses</td>
<td>Bilateral Ear Set</td>
</tr>
<tr>
<td>Contacts</td>
<td>Prosthesis</td>
</tr>
<tr>
<td>Walker</td>
<td>Cane</td>
</tr>
<tr>
<td>Wheelchair</td>
<td></td>
</tr>
</tbody>
</table>

Personal Property

I understand that Memorial Hospital provides a safe for security of valuables without charge for the convenience of its patients and, therefore, Memorial Hospital shall not be liable for the loss of, or damage to, any personal property brought into the hospital unless it is deposited in a safe for safekeeping.

Please check all that apply

- Patient’s personal items were placed in the safe.
- Patient/Family declined to place personal items in the safe and assume responsibility.
- All personal items were sent home.

Admission

Patient Signature: ___________________________  Comments: ___________________________
Staff Signature: ___________________________  Unit: __________  Date: ________  Time: ________

1. Accepting Unit

Patient Signature: ___________________________  Comments: ___________________________
Staff Signature: ___________________________  Unit: __________  Date: ________  Time: ________

2. Accepting Unit

Patient Signature: ___________________________  Comments: ___________________________
Staff Signature: ___________________________  Unit: __________  Date: ________  Time: ________

3. Time of Discharge

Patient Signature: ___________________________  Comments: ___________________________
Staff Signature: ___________________________  Unit: __________  Date: ________  Time: ________