

Patient Rights

I have been given information and instructions about my Patient Rights. My Patient Rights include the right to make medical decisions, including the right to accept or refuse medical treatment, participate in my plan of care and receive care in a safe setting, free from verbal or physical abuse or harassment. I have received a copy of the Patient Rights Booklet. I have received information on how to complete a Mental Health Treatment Declaration regarding my mental health care treatment. I have also received information about the Hospital's grievance process.

Organ Donation

I understand that I may donate any of my organs or tissues for transplantation by completing an anatomical gift form. If I have signed an organ donor card, I understand that the hospital has requested a copy of this card.

Do Not Resuscitate (DNR)

It is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative measures or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Advance Directive or Health Care Power of Attorney.

I have read this document and I understand it. I have signed this Condition of Admission Addendum voluntarily. I have received no promises from anyone about the results of any medical/mental health treatment services.	
<input type="checkbox"/> Patient is medically unable to sign the Condition of Admission Addendum	<input type="checkbox"/> Patient Refused to Sign
Date	Time
Patient/Parent/Guardian/Conservator X	If other than patient, indicate relationship
Spouse (If married/available) X	Witness X



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**CONDITION OF ADMISSION
ADDENDUM**

PATIENT IDENTIFICATION



COA