SAFETY ACKNOWLEDGEMENT

I, _____________________________, have received the St. Anthony’s Hospital Rights and Responsibilities booklet and acknowledge that the hospital’s primary responsibility is to keep patients and staff safe. I understand that the team members, my doctor and other patients have the right to expect reasonable, safe and respectful behavior from patients/visitors.

- **Respect**: I will treat all health care team members with respect and will expect the same.
- **Plan of Care**: I will be included in the formation of my plan of care and once established, I will follow the plan.
- **Personal Belongings**: To maintain a safe environment, patients will not have any objects considered to be weapons and if found, they will be removed and secured until discharge. This includes but are not limited to permitted guns, sharp objects and cigarette lighters/matches. Patients should not take any personal medications unless approved by their admitting hospital physician.
- **Visitors**: Visitors may be monitored while on the premises. Visitors may **not** provide patients with unsafe items. Visitors can be restricted and/or charged with trespassing if they or their actions pose a safety risk to patients, other visitors or to the care team.
- **Smoking**: I understand that St. Anthony’s has a smoke-free campus and **I will not be able to smoke while a patient**. Tobacco-free alternatives such as patches can be made available if requested and approved by the physician.
- **Equipment**: Patients and visitors should not disconnect or handle IV tubing or other medical equipment. Please call for the nurse to manage IV lines, tubing or other equipment.
- **Monitoring**: Patients may be placed on visual monitoring for safety.
- **Other:**
- **Other:**

I recognize that the Hospital has the right and is required to execute their Security and Safety Policies and Procedures to maintain a safe environment for patients, visitors and care providers.

I understand that failure to follow these rules may result in termination of treatment and discharge.

Patient Signature: _____________________________ Date: ________ Time: ________
Witness: _____________________________ Date: ________ Time: ________
Witness (optional) _____________________________ Date: ________ Time: ________