Washington State Department of Social & Health Services
Transforming lives

护士代理服务：
代理服务规程同意书
Nurse Delegation:
Consent for Delegation Process

1. 当事人姓名			2. 出生日期	3. 识别号码/服务环境 (自愿填写)
4. 个案当事人地址	城市	州 邮政编码		5. 电话号码
6. 设施或计划联系人	7. 电话号码	8. 传真号码	9. 电子邮件地址	

10. 服务环境	11. 对当事人之诊断	12. 过敏症
☐ 经认证批准的 发展障碍人士社区住宿看护服务计划		
☐ 领有营业执照的成人之家		
☐ 领有营业执照的生活辅助寄宿机构		
☐ 私人住家/其它		

13. 保健服务提供者	14. 电话号码

代理服务规程同意书

已告知本人，注册护士代理服务指派员仅将护理服务指派给能够胜任并愿意按规定正确履行职责的看护人员。
看护人员必须完成州府规定的培训（华盛顿州行政法规WAC 246-841 405(2)(a)）以及由注册护士代理服务指派员提供的个别培训，之后才能获得护士代理服务指派。本人还明白，下列服务绝对不可指派他人代理：

- 注射给药(IM, Sub Q, IV)，**但胰岛素注射除外。**ESSHB 2668法案（2008年）准许由他人代理胰岛素注射。
- 消毒操作。
- 中心静脉导管护理。
- 要求做出护理判断之护理服务

若获得口头同意，则须在口头同意后30天之内提交书面同意。

15. 个案当事人或授权代表之签名	16. 电话号码	17. 日期
18. 做出口头同意者为	19. 与个案当事人的关系	20. 日期

本人在下面的签名表明，我已对此位个案当事人做了评估，并发现其状况稳定并可预测。本人同意依据华盛顿州修正法规RCW 18.79与华盛顿州行政法规WAC 246-840-910至970条规定而进行护士代理服务指派。

21. 注册护士之姓名 - 请工整填写	22. 电话号码
23. 注册护士之签名	24. 日期

如果您对护士代理服务有任何顾虑或需提出投诉，请打电话，号码是1-800-562-6078。

COPY IN CLIENT CHART AND RND FILE

INSTRUCTIONS – NURSE DELEGATION: CONSENT FOR DELEGATION PROCESS

All fields are required unless indicated **"OPTIONAL".**

1. Client Name: Enter ND client's name (last name, first name).
2. Date of Birth: Enter ND client's date of birth (month, day, year).
3. ID Setting: OPTIONAL – Enter client's ID number as assigned by your business OR enter settings "AFH", "ALF", DDD Program, "In-home".
4. Client Address: Enter the address where the client currently resides, including street address, city, state and zip code.
5. Telephone Number: Enter the telephone including area code where the client can be reached.
6. Facility or Program Contact: Enter the name of facility or name of individual to contact at the facility. Enter N/A if client resides in own home.
7. Telephone Number: Enter the telephone number including area code if different from 5. above.
8. Fax Number: Enter the fax number at the facility if available.
9. E-mail Address: Enter e-mail address of client or facility if available.
10. Setting: Check the appropriate box.
11. Client Diagnosis: Enter client's diagnoses that affect the delegated task.
12. Allergies: List known allergies or "N/A" if none.
13. Health Care Provider: Enter name of client's health care provider.
14. Telephone Number: Enter telephone number including area code of provider named in 13.
15. Client or Authorized Representative Signature: Read the statement to the client/authorized representative and explain the nurse delegation process to them before they sign.
16. Telephone Number: Ask them to enter their telephone number if different from 5. above.
17. Date: Date the signature.
18. Verbal Consent Obtained From: Read the statement to the client/authorized representative and explain the nurse delegation process to them before obtaining verbal consent. Print the name. Written consent must be obtained within 30 days of verbal consent.
19. Relationship to Client: Enter the relationship of the person to the client named in 18. above.
20. Date: Date when you obtained verbal consent.
21. PND Name: Print your name.
22. Telephone Number: Enter your telephone number including area code.

23. & 24. RND Signature and Date: Sign and date your signature verifying consent.