

**Cleveland Clinic Foundation
Bone Marrow Transplant Program
Patient & Care-Partner Agreement**

You have received information about the process of bone marrow transplantation from our team, including the care-partner requirements. To ensure the best possible outcome with your treatment we ask that you read and sign the following agreement, which is between you, your care-partner and the transplant team. Your social worker is available to assist you in planning for your treatment needs.

1. All allogeneic patients must have a dependable 24-hour care-partner to stay with them locally in the home or other lodging arrangement after discharge from the transplant unit. We recommend a single care-partner but it can also be 2-3 family members or friends.
2. All allogeneic patients must stay within one hour driving distance from the transplant center. Patients and care-partners should be prepared to stay in town for at least 100 days after transplant.
3. The care-partner should be supportive, as well as willing to provide hands-on care. We ask that care-partners are able to do the following:
 - Communicate with the BMT team when there is a problem (for example: fevers, bleeding, changes in mental state, severe nausea and vomiting, or uncontrolled pain)
 - Transport the patient to and from the transplant clinic as needed
 - Care for the central venous catheter as instructed
 - Assist with medications and IV medications
 - Assist with nutritional needs, including possible TPN
 - Keep the patient's home or living area clean
4. The transplant team will provide teaching to the care-partner for the tasks listed above. It is the care-partner's responsibility to work with the patient's nurse to set up time for this teaching. This teaching must be done before the patient's discharge from the unit.
5. The care-partner and patient must understand that caregiving needs may extend beyond 100 days post transplant and tentative planning for extended caregiving must to be pursued.

Please sign if you understand and agree with the above terms.

Patient Name: _____

MRN: _____

Patient Signature: _____

Date: _____

Care-partner Signature: _____

Date: _____

Care-partner Signature: _____

Date: _____

Social Worker Signature: _____

Date: _____

Nurse Coordinator Signature: _____

Date: _____

Physician Signature: _____

Date: _____