Caregiver Responsibilities Agreement – Cellular Therapy

___________________________________ ___________________________________

Patient Name (Printed) Patient Medical Record Number (MRN)

Successful cellular therapy treatment requires commitment not only from the patient and medical team, but from the patient's support system as well. Each patient requires a **minimum** of one primary caregiver and one secondary caregiver (a total of 2).

A **caregiver** is a responsible adult family member or friend who is able and willing to provide physical care, observation, reliable transportation and emotional support throughout the treatment process. Private duty caregivers/home care agency staff as well as alternate care settings such as nursing homes, assisted living centers or group homes are **not** acceptable caregiver options.

The caregiver or alternate must be available as needed during the entire treatment process. This includes (but is not limited to) these times:

- Pre-treatment evaluation
- Education sessions
- Weekly visits during hospital admission
- Full-time following discharge from the hospital

Being a caregiver for a cellular therapy patient is a vital role in the treatment process. Please consider the following list of responsibilities and other requirements from the treatment center before agreeing to this commitment:

☐ I/we will be available 24 hours per day after discharge, for a **minimum** of **4 weeks** after cellular therapy infusion, or **longer if medically required** by the cellular therapy physician. I will carry a cell phone with me at all times.

☐ I/we will reside with the patient, within 100 miles of Michigan Medicine, for a **minimum** of **4 weeks** after cellular therapy infusion, or **longer if medically required** by the cellular therapy physician. If the patient's

primary residence is not within 100 miles, I/we will arrange temporary lodging post-discharge within a 100 mile radius.
  - If I/we observe signs of fever or neurologic (thinking-related) changes in patient, I/we will immediately call (734) 936-9814.
  - I/we will attend discharge training, as required by the treatment center
  - I/we will review the educational materials and care instructions provided by the treatment center
  - I/we will ask the treatment center staff questions and be available for communication as needed
  - I/we will coordinate post-discharge care, including appointments, with the treatment center staff as needed

- ☐ I/we will provide the patient's transportation to all appointments and ensure that patient **does not** drive until **medically cleared** by the cellular therapy physician
  - I/we will accompany the patient to all appointments
  - I/we will have an understanding of the patient's medications, assist with administration as needed and keep a log
  - I/we will maintain a clean home environment and assist with daily living functions
  - I/we will follow the treatment plan and any additional requirements set by the cellular therapy care team

By signing below, I indicate that I have reviewed these potential responsibilities and feel comfortable being listed as a caregiver. **If I am unable to fulfill any necessary support throughout the treatment process, I will communicate with the patient and an alternate caregiver to arrange for coverage in my absence.**

1. Primary Caregiver

______________________________	______________________________
Patient Caregiver Name (Printed)	Relationship to Patient
______________________________	______________________________
Primary Caregiver Signature	Contact Number (Cell)

2. **Secondary Caregiver** -individual who acts as a back-up or provides general relief to primary caregiver.

Secondary Caregiver Name (Printed)	Relationship to Patient
Secondary Caregiver Signature	Contact Number (Cell)

Additional Caregivers

As additional caregiver(s) for ________________________________, I/we agree to assist the primary and secondary caregivers with the previously listed responsibilities.

3. Additional Caregiver Information:

Caregiver Name (Printed)	Relationship to Patient
Caregiver Signature	Contact Number (Cell)

4. Additional Caregiver Information:

Caregiver Name (Printed)	Relationship to Patient
Caregiver Signature	Contact Number (Cell)

5. Additional Caregiver Information:

Caregiver Name (Printed)	Relationship to Patient
Caregiver Signature	Contact Number (Cell)

6. Additional Caregiver Information:

Caregiver Name (Printed)	Relationship to Patient
Caregiver Signature	Contact Number (Cell)

7. Additional Caregiver Information:

Caregiver Name (Printed)	Relationship to Patient
Caregiver Signature	Contact Number (Cell)

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