AMBULATORY SURGERY CENTER PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not A Revocation of Advance Directive or Medical Powers of Attorney

ALL PATIENTS HAVE THE RIGHT TO PARTICIPATE IN THEIR OWN HEALTH CARE DECISIONS AND TO MAKE ADVANCE DIRECTIVES OR TO EXECUTE POWERS OF ATTORNEY THAT AUTHORIZE OTHERS TO MAKE DECISIONS ON THEIR BEHALF BASED ON PATIENT'S EXPRESSED WISHES WHEN THE PATIENT IS UNABLE TO MAKE OR UNABLE TO COMMUNICATE DECISIONS. THIS SURGERY CENTER RESPECTS AND UPHOLDS THOSE RIGHTS.

HOWEVER, UNLIKE IN AN ACUTE CARE HOSPITAL SETTING, THE SURGERY CENTER DOES NOT ROUTINELY PERFORM "HIGH RISK" PROCEDURES PERFORMED IN THIS FACILITY ARE CONSIDERED TO BE OF MINIMAL RISK, OF COURSE, NO SURGERY IS WITHOUT RISK. YOU WILL DISCUSS THE SPECIFICS OF YOUR PROCEDURE WITH YOUR PHYSICIAN WHO CAN ANSWER YOUR QUESTIONS AS TO ITS RISKS, YOUR EXPECTED RECOVERY, AND CARE AFTER YOUR SURGERY.

THEREFORE, 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 INIATE RESUSCITATIVE OR OTHER STABLIZING 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 HEALTH CARE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY.

IF YOU DO NOT AGREE TO THIS POLICY, WE ARE PLEASED TO ASSIST YOU TO RESCHEDULE THE PROCEDURE.

PLEASE CHECK THE APPROPIATE BOX IN THE ANSWER TO THESE QUESTIONS; HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, AND A POWER OF ATTORNEY THAT AUTHORIZES SOMEONE TO MAKE HEALTH CARE DECISIONS FOR YOU?

☐ YES, I HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.

☐ NO, I DO NOT HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.

☐ I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES.

IF YOU CHECKED THE BOX "YES" TO THE QUESTION ABOVE, PLEASE PROVIDE US A COPY OF THAT DOCUMENT SO THAT IT MAY BE MADE PART OF YOUR MEDICAL RECORD.

BY SIGNING THIS DOCUMENT, I ACKKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECIEPT OF THAT INFORMATION.

BY: _____

(PATIENTS SIGNATURE)

PATIENT'S LAST NAME:	PATIENT'S FIRST NAME:	DATE:

IF CONSENT TO THE PROCEDURE IS PROVIDED BY ANYONE OTHER THAN THE PATIENT, THIS FORM MUST BE SIGNED BY THE PERSON PROVIDING THE CONSENT OR AUTHORIZATION.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND SGREE TO THE POLICY AS DESCRIBED.

BY: _____

(SIGNATURE)

BY: _____

(PRINT NAME)

RELATIONSHIP TO PATIENT:

☐ COURT APPOINTED GUARDIAN

☐ ATTORNEY IN FACT

☐ HEALTH CARE SURROGATE