PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not A Revocation of Advance Directives 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 other:s to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Center respects and upholds those rights.

However, unlike in an Acute Care Hospital setting, the Center does not routinely perform "high risk" procedures. Most 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, regardless of the contents of any advanced directive or instructions from a healthcare surrogate or attorney, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures & transfer you to an acute care setting for further evaluation. If you have an advanced directive, it is your responsibility to inform us of detailed information and provide a copy to our center on the day of the procedure.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

PLEASE CHECK THE APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS.

Have you executed an Advance Health Care Directive, A Living Will, or a Power of Attorney that authorizes someone to make health care decisions for you?

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

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

o I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES.

If you checked the first box "yes" to the question above, please provide us a copy of that document so that It may be made a part of your medical record.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described.

By: Patient's 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 agree to the policy as described. By:

Signature Print Name.

Relationship to Patient:

o· Court Appointed Guardian o Attorney in Fact ti Health Care Surrogate □ Other