NORTH COUNTRY ORTHOPAEDIC

AMBULATORY SURGERY CENTER

Accredited by
Accreditation Association
for Ambulatory Health Care, Inc.

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 THE PATIENT'S EXPRESSED WISHES WHEN THE PATIENT IS UNABLE TO MAKE DECISIONS OR UNABLE TO COMMUNICATE DECISIONS. THE 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. 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, 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 INITIATE RESUSCITATIVE OR OTHER STABILIZING MEASURES AND TRANSFER YOU TO AN ACUTE CARE HOSPITAL FOR FURTHER EVALUATION. AT THE ACUTE CARE HOSPITAL FURTHER TREATMENT OR WITHDRAWL 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 WITH THIS POLICY WE ARE PLEASED TO ASSIST YOU IN RESCHEDULING THE PROCEDURE.

PLEASE CHECK THE APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS. HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, 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.

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

☐ Attached ☐ Patient did not provide copy

☐ 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.

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

BY: _____ DATE: _____
(SIGNATURE)
PRINT LAST NAME: _____ PRINT FIRST NAME_____

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:
☐ COURT APPOINTED GUARDIAN ☐ ATTORNEY IN FACT
☐ HEALTH CARE SURROGATE ☐ OTHER _____ rev. 5/9/2013