RiverPointe Surgery Center

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 decision and to make Advance Directives or to executive 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. RiverPointe Surgery Center respects and upholds those rights.

However, unlike in an Acute Care Hospital setting, RiverPointe 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 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 withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Directive or Health Care Power of Attorney.

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

Please check the appropriate box below. Have you executed an Advance 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.
☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney, but I have no copy with me.
☐ 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 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. If I have indicated, I would like additional information, I acknowledge receipt of that information.

By:_____ Date:_____
(Patient's Signature)

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 Pact
☐ Health Care Surrogate
☐ Other _____