Surgery Center Rules

In 1990, Congress passed a federal law called the "Patient Self-Determination Act", which requires all adult patients to be informed about their right to refuse or accept medical or surgical treatment and their right to execute an Advance Directive. The term advance directive stands for a document that communicates the person's wishes as to what medical or surgical care that patient wants to receive if he/she is unable to convey those directions. These documents are known by different names in various states and may be presented to you as a "Living Will, "Healthcare Durable Power of Attorney", or an "Advance Healthcare Directive."

In surgery centers where patients are admitted and expected to go home after surgery there is an expectation that in the event of an emergency, all treatment available to resuscitate a person will be rendered regardless of any pre-written document with contrary instruction. Since the person has the right to these documents, we do not ask them to waive their rights or even suspend them; we only ask for the right to resuscitation while being in our facility.
That is the purpose of the documents enclosed.

The purpose of requesting's Advance Directive is to know his/her wishes and have them documented in the event of an occurrence where he/she may have continuation of care at another facility. In the rare event of refusing to consent to resuscitative measures, the center would follow their written policy to refuse surgery and assist the patient in scheduling their surgery elsewhere.

Advance Directives Policy

Standard An Ambulatory Surgery Center, by its nature, performs predominantly elective procedures. The Surgery Center does not provide continuing care, and the need for Advance Directives has not been established for same day elective surgery patients.

Policy The Surgery Center will not honor any patient or family request for a "No Code" or "DNR" for any procedure scheduled at the Center. If the patient should present with an Advance Directive (i.e., Living Will) that is to be followed in the event he/she could not make his/her wishes known concerning emergency life prolonging procedures, the following procedure will be followed.

Procedure The patient and physician will be notified that the procedure will have to be cancelled if they are insistent on a "DNR" status.

In the event of a transfer of the patient to another medical facility, the receiving facility will be notified in advance of the transfer that the patient has Advance Directives.

If the patient does not have an Advanced Directive, an informational brochure will be provided.

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 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. 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. 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 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 APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS. HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, OR A HEALTHCARE 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 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: _____

(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

COURT APPOINTED GUARDIAN ATTORNEY IN FACT

HEALTH CARE SURROGATE OTHER _____