

## THE ADVANCE DIRECTIVE

- ❖ The Providence Surgery Center recognizes that the purpose of being an ambulatory surgery center is to provide elective surgical procedures to ASA Class I, II and stable III patients. 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.
- ❖ As part of your right to make your personal health care decisions, you may accept or refuse any recommended medical treatment. This is relatively easy when you are well and can speak for yourself. Unfortunately, during severe illness, you may be unconscious or otherwise unable to communicate your wishes – at the very time when many critical decisions may need to be made. An ADVANCE DIRECTIVE communicates your wishes for medical care so that the choices people make on your behalf reflect your wishes. An ADVANCE DIRECTIVE comes into effect only if you become unable to express your beliefs and values and are unable to make decisions concerning your health care. You may change it at any time until then.
- ❖ ADVANCE DIRECTIVE documents may include The Living Will; the Durable Power of Attorney for Health Care; and The Comfort One. These documents allow you to communicate your care wishes to your care providers and others. By holding these discussions while you are healthy, thinking clearly and in control of your life, you can help your family to understand your feelings and carry out your wishes on a variety of serious problems.
- ❖ At the Providence Surgery Center you will be asked about your Advance Directive when you register for your procedure. You will be asked to indicate your wishes in regards to suspending your Advance Directive during your procedure. If you have not done so before, then after consultation with the physician and/or anesthesiologist, you will be asked if you consent to resuscitative measures if an adverse event occurs during your treatment at this facility.
- ❖ If you would like more information regarding ADVANCE DIRECTIVES you may contact **Montana’s End-of-Life Registry Department of Justice, Helena, Montana: phone 1-866-675-3314 or online at [www.EndofLife.gov](http://www.EndofLife.gov)** ; the American Association of Retired Persons (AARP) at 1-800-441-2277; or your attorney.

# PROVIDENCE SURGERY CENTER

## PATIENT CONSENT TO RESUSCITATIVE MEASURES

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.

It is our policy that if you have an advance directive, living will or health care power of attorney; you may consent to resuscitative measures 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 if allowed in your document or by this waiver. 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 and hospital policy.

Please initial 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

\_\_\_\_ I DO NOT consent to resuscitative or stabilizing measures in case of an adverse event.

\_\_\_\_ I consent to resuscitative or stabilizing measures in the case of an adverse event

\_\_\_\_ 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:
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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:

- PARENT OR COURT APPOINTED GUARDIAN
- ATTORNEY IN FACT
- HEALTH CARE SURROGATE
- OTHER \_\_\_\_\_