SUMMIT
SURGERY CENTER
OF SANTA BARBARA

Patient Consent To Resuscitative Measures

** PLEASE BRING WITH YOU TO YOUR SCHEDULED APPOINTMENT**

NOT A REVOCATION OF ADVANCE DIRECTIVES OR MEDICAL POWERS OF ATTORNEY

Under California law, 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. Summit Surgery Center (SSC) respects and upholds those rights.

The majority of procedures performed at SSC are considered to be of minimal risk. Of course, no procedure is without risk. You and your physician will have discussed the specifics of your procedure and the risks associated with your procedure, the expected recovery and the care after your procedure.

It is the policy of SSC, 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 SSC, the personnel at SSC 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, SSC will be pleased to assist you to reschedule the procedure.

Please check the appropriate box in answer to this question: Have you executed an advance health care directive, a living will, or 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 more information on Advance Directives.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have asked for information on Advance Directives, I acknowledge receipt of that information.

_____

Patient Signature | Patient Name (print) | Date

If consent signed by other than the Patient:

_____

Signature | Name (print) | Date

Relationship: ❍ Guardian (court appointed) ❍ Attorney-in-fact ❍ Healthcare Surrogate