

**Attachment A: Patient Consent to Resuscitative Measures**

**Patient Consent to Resuscitative Measures**

Spivey Station Surgery Center requires the following notice be signed by each patient prior to the scheduled procedure in order to be in compliance with the Patient Self-Determination Act (PSDA) and State law and rules regarding Advance Directives. Advanced Directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The Advanced Directives are made and witnessed prior to serious illness or injury.

There are many types of Advanced Directives but the two most common forms are:

**Living Wills**

These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her decision.

**Durable Power of Attorney for Health Care**

This is signed, dated and witnessed paper naming another person as an individual’s agent or proxy to make medical decisions.

**In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, this signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed Advanced Directives for any patient. If you disagree, you must address this issue with your physician prior to signing this form.**

\_\_\_\_ I understand that I am not required to have an Advanced Directive in order to receive medical treatment in this health care facility.

\_\_\_\_ I have executed an Advanced Directive and have been asked to provide a copy to the Surgery Center.

\_\_\_\_ I have not executed an Advanced Directive.

\_\_\_\_ I have read and fully understand the information presented in this release form.

\_\_\_\_\_  
Witness to Patient’s Signature

\_\_\_\_\_  
Patient’s Signature

Date: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is unable to sign or is a minor, please sign below:

\_\_\_\_\_  
Witness to Relative/Guardian Signature Closest Relative or Legal Guardian’s Signature