PECOS VALLEY EYE SURGERY CENTER
SPECIAL SURGICAL PROCEDURE CONSENT
DNR ORDERS

Not a Revocation of Advance Directive or Medical Powers of Attorney

The Pecos Valley Eye Surgery Center respects and upholds the rights of all patients to participate in their own health care decisions. When patients are unable to make these decisions for themselves, Advance Directives or executed Powers of Attorney are recognized authorization of care.

Unlike 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. Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a Durable Power of Attorney, that if an adverse event occurs while at the Pecos Valley Eye Surgery Center, 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 will be instituted in accordance with your wishes, Advance Directive or Durable Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Advanced Directive or Durable Power of Attorney.

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

Please check the appropriate box in answer to these questions. Have you executed an Advance Health Care Directive, a Living Will or 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
  - Please bring a copy of this document to the Pecos Valley Eye Surgery Center on the day of your surgery.
- □ 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

By signing this Document, I (or my patient representative) acknowledge that I have read and understand its contents and agree to the policy as described.

Patient: _____ Printed Name: _____Date:_____

_____
(Representatives Signature)

_____
(Printed name of Representative)

Other:_____

Relationship to Patient:
□ Court appointed Guardian
□ Durable Power of Attorney

_____ Date: _____