CONSENT TO RESUSCITATIVE MEASURES/TRANSFER

NOT A REVOCATION OF ADVANCED 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.

However, unlike in an inpatient acute hospital setting, the UTMB Specialty Care Center does not routinely perform "high risk" procedures. Most procedures performed in the Center 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 advanced directive or instruction from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at the Center we will initiate resuscitative or other stabilizing measures and transfer you to the main campus of UTMB Galveston or another inpatient 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 advanced 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.
☐ NO, I DO NOT HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.
☐ I WOULD LIKE TO HAVE INFORMATION ON ADVANCED 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 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) __________________________ (TIME) __________________________

RELATIONSHIP TO PATIENT:
☐ Court Appointed Guardian
☐ Attorney In Fact
☐ Health Care Surrogate
☐ Other

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED.

BY: ___________________________ (PATIENT'S SIGNATURE) 
(PRINT NAME):
(DATE) __________________________ (TIME) __________________________

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UWH IN SPACE BELOW

CONSENT TO RESUSCITATIVE MEASURES/TRANSFER

UTMB Specialty Care Center at Victory Lakes

Medical Record Form 6000VL–6/10
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original–Medical Record
Yellow–Patient