Patient Informed Consent to Resuscitative Measures
(Not Revocation of Advance Healthcare Directive or Medical Power of Attorney)

You have the right to accept or refuse medical or surgical treatment, and to participate in your healthcare decisions. You may complete and sign an Advance Healthcare Directive or a Power of Attorney authorizing others to make decisions for you, based upon your wishes, if you are unable to otherwise make or communicate your decisions. The Institute of Orthopaedic Surgery respects and upholds those rights and references Nevada Revised Statues 449.628 in the declaration of the following policy. A link to the Nevada Division of Health Care Financing and Policy can be found on the IOS Web site at www.ioslv.com, where you will also find more information on Advance Healthcare Directive. IOS has Advance Directive forms available upon request.

The Institute of Orthopaedic Surgery (IOS) does not routinely perform high risk procedures like an acute care hospital. While no surgery is without risk, those performed at IOS are considered to be of minimal risk. The specifics of your procedure, including the risks, recovery and aftercare, will be discussed with your surgeon.

Therefore, it is IOS policy, regardless of any Advance Healthcare Directive or instructions from a Health Care Surrogate or Attorney, that if an adverse event occurs during your treatment at IOS, resuscitative or other stabilizing measures will be initiated and you will be transferred to an acute care hospital for further evaluation. At the acute care hospital, further treatment, withdrawal of treatment or withdrawal of treatment measures already begun, will be ordered in accordance with your wishes, Advance Healthcare Directive, or Health Care Power of Attorney. Your signature, below, does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree with this policy, we are pleased to assist you in rescheduling this procedure. Otherwise, **please initial the appropriate box, below**.

______Yes, I have an Advance Healthcare Directive, Living Will or Healthcare Power of Attorney.
______No, I do not have an Advance Healthcare Directive, Living Will or Healthcare Power of Attorney.
______I would like Advance Healthcare Directive information.

By signing this document, I acknowledge I have received this information both verbally and in writing in advance of the date of my procedure.

Patient Signature: ____ Date: ___________

If consent to the procedure is provided by anyone other than the patient, the person providing the consent must sign this form, below:

Patient Advocate Signature: ____ Date: ___________

Print Advocate Name: ____

Relationship to Patient:

- ☐ Court appointed guardian
- ☐ Healthcare Surrogate
- ☐ Attorney in fact
- ☐ Other: ______________________

____
Institute of Orthopaedic Surgery Employee

INSTITUTE OF ORTHOPAEDIC SURGERY
2800 E. Desert Inn Road, Suite 150
Las Vegas, NV 89121
702-735-7355

PATIENT IDENTIFICATION