University Orthopaedic Surgery Center

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES

University Orthopaedic Surgery Center requires that the following notice be signed by each patient prior to a scheduled procedure in order to comply with federal and state laws and rules regarding Advance Directives. Advance Directives can be statements that indicate the type of medical treatment an individual does or does not want if he/she is unable to make those determinations or to authorize others to make medical decisions for the individual if he/she is unable to do so.

In Tennessee, patients have several options for making Advance Directives:

Advance Care Plan (or Living Will)
These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own healthcare decisions.

Appointment of HealthCare Agent (or Durable Power of Attorney for Health care)
These forms allow an individual to name someone to make healthcare decisions for him/her if he/she becomes unable to make healthcare decisions.

In an ambulatory care setting, such as UOSC, if a patient suffers from cardiac or respiratory arrest or other life-threatening situation, a signed consent form implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, UOSC is notifying you that it will not honor previously signed Advance Directive for any patient. It is still important that you provide UOSC with a copy of your Advance Directive, as it will be sent with you should you require a transfer to a higher level of care.

Your agreement with this policy by your signature below does not revoke or invalidate your Advance Directive.

If you do not agree with this policy, please address this issue with your physician prior to signing this notice.

- € I understand that I am not required to have an Advance Directive in order to receive medical treatment at UOSC.
- € I have executed an Advance Directive.
- € I have not executed an Advance Directive.
- € I would like information on Advance Directives.

If you checked the second box, please provide us with a copy of your Advance Directive so that it may be made part of your medical record.

I have read and fully understand the information presented in this notice.

_____ _____ _____
Patient Signature Witness Date

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

_____ _____ _____
Authorized Representative Witness Date