HOUSTON METRO ORTHO AND SPINE
SURGERY CENTER
4219 Richmond Avenue Suite 200, Houston Texas 77027
Phone #713-487-0001 Fax #713-487-0002

Advanced Directives

Patient Name: _____ Date: _____

Sex: _____ Date of Birth: _____

PLEASE READ SECTION BELOW. IF YOU HAVE ANY QUESTIONS, PLEASE ASK OUR STAFF BEFORE SIGNING.

— ADVANCED DIRECTIVES —

Definition: An advance directive is written instruction, such as a Living Will or a Durable Power of Attorney for Health Care. These documents provide information to the doctors and staff regarding your health care decisions should you be unable to express your wishes later. The center wishes to inform you that in the event of a life-threatening episode, the staff will make every effort to revive and/or resuscitate you as a patient. If your wishes are otherwise, it is your responsibility to make us aware of this. You will be immediately transferred to the hospital by ambulance where you will be treated as a patient.

I understand that I am not required to have an advance directive in order to receive medical treatment at the center, but should transfer be necessary a copy of the directive, if provided to the center, will be retained in the patient's records that will be transferred to the hospital at the time of admission, and will be executed by that facility in accordance with the law and policies and procedures.

PLEASE CHECK THE FOLLOWING THAT APPLIES:

Living Will: _____ Copy Given to Center: _____ Advanced Directives: _____ Copy given to Center: _____
No Advance Directives: _____ Do Not Resuscitate: _____
Health Care Proxy: _____ Durable Power of Attorney: _____

— EMERGENCY HOSPITAL TRANSFER —

In the event of an emergency, the hospital you wished to be transferred to _____ hospital.

— RELIGIOUS/CULTURAL PREFERENCE —

Do you have any religious or cultural preference that may interfere with your treatment protocol? Yes No
If yes, please explain _____
_____

— DISCLOSURE STATEMENT —

The center is privately owned and managed by a group of physicians. Your physician may be an investor in this center. As a patient, you have the right to choose the facility of your choice for health related services. I have been informed of my Rights and Privacies as a patient before treatment and received a copy of Patient's Rights and Privacies and understand diem.

— CONSENT FOR BLOOD TESTING —

I understand that it is possible during the course of a stay; a health care worker could become contaminated with my blood or body fluids. In the event that this should occur, I hereby give my consent to have my blood tested for communicable diseases such as Hepatitis and Acquired Immune Deficient Syndrome (AIDS).

Routine procedure of obtaining blood has the potential side effect of discomfort from needle stick, slight bruising, bleeding or soreness at the site.

The center will maintain the confidentiality of my test results. If the results are positive for any infectious diseases I will be notified and provide with information regarding follow up. I have read and understand all the information above.

Patient: _____ Witness: _____

Parent of Guardian: _____ Date: _____ Relationship to Patient: _____

The patient is unable to sign or give consent for the following reason: _____

Minor (unmarried, under 18 years of age): _____ Physical Condition: _____

Mentally Incompetent: _____ Other: _____

In the Event of an Emergency, Notify: _____

Phone Number: _____ Relationship: _____

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