

POLICY: Information regarding advance directives will be made available to patients at their request.

1. "Advance Directives - Your Right to Decide" from the Indiana State Department of Health information (English and Spanish versions) will be kept in the Clinical Director/Administrator's office, at the Endoscopy Nurse's station, and at the reception desk. This information will be given to patients at their request.
2. SurgiCenter staff, physicians, and new employees are inserviced regarding advance directives.
3. When a patient presents Advance Directives upon admission, the document will be scanned into the electronic medical record. An "Alert" note will be posted in the EMR indicating that a copy of the Advance Directive is in the EMR.
4. Because IMA Endoscopy SurgiCenter does not perform procedures considered to be life-threatening, and only performs procedures on an elective basis, advance directives are not recognized. However, if the patient's condition becomes life-threatening, the patient will be stabilized and transferred to Methodist Hospital. A copy of the patient's advance directive will accompany the patient and will be appropriately honored by the hospital.
5. A copy of this policy is mailed to all IMA Endoscopy SurgiCenter patients prior to the date of the procedure. All patients utilizing the Center are questioned during the pre-admission nursing assessment as to whether they would like information on Advance Directives. The answer is documented on the pre-op assessment form in the medical record and on the patient's copy of the policy.
6. Patients are instructed to review the material prior to the procedure date and to bring the material with them on the day of the procedure. A staff member will contact the patient to review the information with the patient. This phone call will allow the patient the opportunity to discuss or ask any questions.

End of Policy.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of the information. My signature does not revoke or invalidate any current health care directive or health care power of attorney.

I would like more information on Advance Directives.

By: _____
Patient's signature

Date

Name _____

MR# _____

DOB _____