

Pueblo Endoscopy Suites, L.L.C

ADVANCED DIRECTIVES

An advanced 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 become unable to express your wishes later. If you choose to be a do not resuscitate (DNR), we must have a copy prior to your procedure.

I understand I am not required to have an advance directive in order to receive medical treatment. If a hospital transfer is required, a copy of my advanced directives, if provided to the facility, will accompany me to the hospital.

Please check the following:

Advanced Directive: Yes _____ No _____ Copy provided to the facility? Yes _____ No _____

Living Will: Yes _____ No _____ Copy provided to the facility? Yes _____ No _____

Durable power of attorney: Yes _____ No _____

Name and relationship of power of attorney _____

Hospital Transfer

In the event of an emergency, you wish to be transferred to:

Parkview Medical Center **OR** St. Mary-Corwin Medical Center

Religious Preference

Do you have any religious or cultural preferences that may interfere with your treatment?

Yes _____ No _____

If yes, please explain: _____

Do you wish to sign a refusal for a blood transfusion? Yes _____ No _____

Print Name/ Date of Birth

Patient Signature

Date

Staff Signature

Date

CONTINUE ON BACK →

Pueblo Endoscopy Suites, L.L.C.

I have received the following information in my Registration Packet.

The following information was reviewed in writing:

- _____ Bowel preparation and/or diet instructions
- _____ PES parking notification
- _____ PES educational information:
Patient rights, Grievance Information, Financial Policy & Physician Owned Disclosure
- _____ Advanced Directive Information & completed the Advance Directive Form

Please initial next to the following; failure to comply with the following items may result in a cancellation and rescheduling of your procedure:

- _____ I understand I cannot have marijuana and/or alcohol 24 hours prior to my procedure.
- _____ I understand that I will need to have an adult over the age of 18 to drive me home and that no public transportation is permitted.
- _____ I understand that I cannot have anything by mouth FOUR HOURS prior to my procedure.

Patient Signature

Date

Staff Signature

Date

If you received this information in the mail, please complete and mail back. Thank you.