SELECT SURGICAL CENTER AT KENNEDY

405 Hurffville-Crosskeys Road
Suite 210
Sewell, NJ 08080
(856)-582-2072

PLEASE READ THE FOLLOWING FIVE (5) STATEMENTS
Place your initials after EACH Statement
I have reviewed this information at least 24 hours prior to surgery

1. I have been given written material and an explanation of my patient rights and responsibilities. _____

2. I have been informed of my rights to formulate Advance Directives. _____

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment in this Healthcare facility. _____

4. I understand that it is the policy of this surgery center to resuscitate all patients that requires resuscitation in order to maintain their vital functions. _____

5. I understand that in the case of an emergency that I may be transferred to a local hospital. In such a case, and executed copy of an Advance Directive that I have provided to this surgery center will be communicated to the hospital to which I have been transferred. _____

PLEASE CHECK ONE (1) OF THE FOLLOWING STATEMENTS:

_____ I HAVE executed an Advance Directive. Location of Advance Directive._____

_____ I HAVE NOT executed an Advance Directive.

Signed_____

Date_____

Witness_____

Date_____

Reviewed by_____Date_____