**Center Name**

**Confirmation of Non-Elective Surgery Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Scheduled Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, confirm the following:

1. I am aware that due to COVID-19, an Executive Order has been issued requiring hospitals and ambulatory surgery centers to cancel or postpone elective procedures.
2. I have evaluated any applicable state, CDC, and CMS guidelines regarding the cancellation or postponement of elective procedures.
3. I have evaluated the supply and availability of essential medical equipment and supplies.
4. I have evaluated the above-referenced patient condition and need for this procedure in light of the above mentioned considerations, and have determined that, in my professional judgement, the risk to the patient that would result from postponing or cancelling this procedure is such that the proposed procedure is not elective and the procedure is likely necessary to sustain life, preserve a bodily function, or prevent serious harm from an underlying condition. Specific risk factors include:

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Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_