WINDSOR REGIONAL HOSPITAL OUTSTANDING CARE – NO EXCEPTIONS!	**COVID-19 Pandemic** **Attestation of Surgical Patient Urgency**	*Patient Name:* *DOB:*

I, _____ hereby attest to my belief that a delay in the
(Surgeon Name)

above-named patient's surgical procedure _____
(Surgical Procedure) (Date)

by 4 weeks or more will have a significant negative impact on the patient and/or his/her condition, in the following manner(s):

[ ] High probability of requirement for Emergency Department or Acute Hospital admission due to progression of disease signs or symptoms: (*Details must be provided)*

_____

_____

_____

_____

[ ] Significant and irreversible progression of disease: (*Details must be provided)*

_____

_____

_____

_____

[ ] Significant pain or suffering: (*Details must be provided)*

_____

_____

_____

_____

Signature: _____ Date: _____
(Surgeon signature)