**ADVANCED DIRECTIVES**

(For Compliance with the Patient Self-Determination Act)

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_**

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| Have you executed an advanced directive? YES \_\_\_\_\_\_ NO \_\_\_\_\_\_  If YES, is this directive in the form of:  \_\_\_\_ A Living Will  \_\_\_\_ A Durable Power of Attorney  \_\_\_\_ A Health Care Surrogate (Someone to make decision for you)  \_\_\_\_\_\_ DNR ( Do Not Resuscitate)  Have you provided this office with a copy of Advanced Directive?  YES \_\_\_\_\_ NO \_\_\_\_\_  If you would like more information regarding advanced directives please ask the nurse or receptionist. Forms are supplied in the office lobby for you |

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| I have been provided with information regarding the “PATIENT SELF-DETERMINATION ACT” |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or representative Date

Have you executed an advanced directive? YES \_\_\_\_\_\_ NO \_\_\_\_\_\_

If YES, is this directive in the form of:

\_\_\_\_ A Living Will

\_\_\_\_ A Durable Power of Attorney

\_\_\_\_ A Health Care Surrogate

Have you provided this office with a copy of Advanced Directive?

YES \_\_\_\_\_ NO \_\_\_\_\_

If you would like more information regarding advanced directives please ask the nurse or receptionist.