

ADVANCED DIRECTIVES

(FOR COMPLIANCE WITH THE PATIENT SELF-DETERMINATION ACT)

NAME _____ ID# _____

- 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

- IF YOU HAVE EXECUTED AN ADVANCED DIRECTIVE IN ANY OF THE ABOVE FORMATS, HAVE YOU PROVIDED THIS OFFICE WITH A COPY FOR YOUR MEDICAL RECORDS?

YES _____ NO _____

- IF YOU WOULD LIKE MORE INFORMATION REGARDING ADVANCED DIRECTIVES, PLEASE ASK THE NURSE.

SIGNATURE _____

DATE _____