

ADVANCED DIRECTIVES ACKNOWLEDGEMENT FORM

Patient Name: _____ Date: _____

_____ I *do have* an Advanced Directive / Living Will / Durable Power of Attorney for medical or health care decisions.

_____ I *do not have* an Advanced Directive / Living Will / Durable Power of Attorney for medical or health care decisions.

_____ Date: _____
Patient's Signature

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FOR ADMINISTRATIVE USE ONLY:

_____ Written information regarding Advanced Directives *was provided*.

If the patient has an Advanced Directive, has it been placed in the Medical Record?:

_____ Yes _____ No

Comments:

Staff Signature: _____ Date: _____