**ADVANCE DIRECTIVE ACKOWLEDGEMENT 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.  |

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

**Patient’s Signature Date:**

**FOR ADMINISTRATIVE USE ONLY:**

|  |  |
| --- | --- |
| 🞐 | Written information regarding Advance Directive ***was provided***.  |

|  |  |
| --- | --- |
| 🞐 Yes 🞐 No  | If the patient has an Advance Directive, has it been placed in the Medical Record?  |

|  |  |
| --- | --- |
| **Comments** |  |

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**Staff Name/ Signature Date:**