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	

_____

Staff Name/ Signature **Date:**