Date: _____

I, _____, have discussed Advance Health Care
(PCP Name)

Directives with _____ on _____
(Patient Name) (Date)

and have given a copy of the Advance Health Care Directive form to the patient.

_____
PCP Signature

I, _____, acknowledge discussing Advance
(Patient Name)

Health Care Directives with my PCP, _____,
(PCP Name)

on _____.
(Date)

☐ I received a copy of the Advance Health Care Directive form.

☐ I declined a copy of the Advance Health Care Directive form.

☐ I already have an Advance Health Care Directive and have given a copy to my PCP noted above.

_____
Patient Signature

ADVANCE DIRECTIVE STATUS

I have been informed of my right to formulate an Advance Directive and I have been provided with information regarding the execution of an Advance Directive.

Please check one of the following:

☐ I have previously completed an Advance Directive and have provided a copy for inclusion in my medical record.

☐ A copy of my Advance Directive is on file with _____.
(Physician or health care facility)

☐ I have not executed an Advance Directive and I am not interested in any further information.

☐ I am interested in the formulation of an Advance Directive and will discuss my options with my Primary Care Provider (PCP).

☐ I was given a brochure / information on Advance Health Care Directives by my PCP office.

Comments:
_____
_____
_____
_____

_____ _____
Patient's Signature Date

_____ _____
Office Staff Signature Date

Patient Name (printed):	**DOB:**