

ADVANCE DIRECTIVES PATIENT ACKNOWLEDGMENT

(PLEASE PRINT)

PATIENT NAME:	PATIENT NUMBER:
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Please read the following statements about Advance Directives and complete the form as indicated. Your signature and date signed are necessary for TideWell's records.

1. I have been informed of my right to execute Advance Directives and given written materials regarding my right to accept or refuse medical treatment, in the form of Living Wills, Durable Medical Power of Attorney, Designation of a Health Care Surrogate and Do Not Resuscitate Orders.

2. I have completed and signed the following directives:

	COMPLETED	VERIFIED	COPY OBTAINED
Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Durable Medical Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Designation of Health Care Surrogate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do Not Resuscitate Order	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. The name and address of my Health Care Surrogate on the document dated _____ is:

Name _____

Address _____

City/State/Zip _____

Relationship _____ Phone Number _____

4. The name and address of my Durable Medical Power of Attorney holder is:

Name _____

Address _____

City/State/Zip _____

Relationship _____ Phone Number _____

5. I understand that the terms of my Advance Directives will be followed by TideWell Hospice and Palliative Care and my caregivers to the extent permitted by law.

6. I would like more information about Advance Directives and the forms for implementation.

(Please indicate which forms you need.)

- | | |
|--|---|
| <input type="checkbox"/> Living Will | <input type="checkbox"/> Designation of Health Care Surrogate |
| <input type="checkbox"/> Durable Medical Power of Attorney | <input type="checkbox"/> Do Not Resuscitate Order |

Patient Signature _____ Date _____

Witness _____ Date _____

If patient is unable to sign, please give reason _____

Information provided by _____