**ADVANCE DIRECTIVES ACKNOWLEDGEMENT FORM**

Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

\_\_\_\_\_\_\_\_ I **would like** further information on Advance Directives

**\_\_\_\_\_\_\_\_** I **would not like** further information on Advance Directives.

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

**OFFICE STAFF USE ONLY:**

\_\_\_\_\_\_\_\_ Information regarding Advance Directives **was provided.**

Information was provided, what type? \_\_\_\_\_ Verbal \_\_\_\_\_ Written

If the member has an Advance Directive, has it been placed in the Medical Record?

\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_ NO

**\_\_\_\_\_\_\_\_** Information regarding Advance Directives **was not provided.**

**Comments:**

**Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**