ADVANCE DIRECTIVE

Date:____/____/_____

Patient name:_____ Acct #: _____

DOB: _____

Do you have a living will? Yes/ No

Do you have a Health Care Proxy? Yes/ No

If yes? Name:_____ Phone#: (_____)_____-_____

Relationship: _____

Do you have a Do-Not-Resuscitate (DNR)? Yes/No

I am not ready to fill out this form. Please ask me about this in the future.

Patient/Legal guardian/Representative_____Date:____/____/____

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