ACKNOWLEDGEMENT OF RECEIPT
ADVANCE DIRECTIVES/MEDICAL TREATMENT DECISIONS

This is to acknowledge that I have been informed in writing, in a language that I understand, of my rights (as well as all rules and regulations) to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate and to issue Advance Directives to be followed should I become incapacitated.

❍ **I have chosen to formulate and issue the following Advance Directives.**
I understand it is my responsibility to provide copies of all pertinent documentation to the facility that verifies the advance directive(s) specified below for placement in my medical record.

DATE ENACTED		DATE ENACTED	
_____	❑ Living Will		❑ Medication Restrictions specify
_____	❑ Do Not Resuscitate	_____	_____
_____	❑ Do Not Hospitalize		❑ Other Treatment Restrictions
_____	❑ POLST/MOLST; POST/MOST	_____	❑ Tube/Feeding _____
_____	❑ Organ Donation	_____	❑ Intubation/Ventilator _____
_____	❑ Autopsy Request		❑ Other Advance Directives specify below
_____	❑ Other _____	_____	_____
		_____	_____

❍ **I do not choose to formulate or issue any Advance Directives at this time.**
I want efforts made to prolong my life and I want life-sustaining treatment to be provided.

ACKNOWLEDGEMENT SIGNATURES

Resident/Patient/Client X _____ Date _____

Legal Representative _____ Date _____

If Legal Representative Signed, Complete the Following:

Print Name _____ Relationship to Resident/Patient/Client _____ Type of Legal Appointment _____

Witness _____ Date _____

Witness _____ Date _____
(Second Witness Signature Required if Acknowledged by Resident/Patient/Client "Mark".)

If Resident/Patient/Client Unable to Sign Name, State Medical Reason:

Physician Signature _____ Date _____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed