

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.

<p>DATE ENACTED</p> <p>_____ <input type="checkbox"/> Living Will</p> <p>_____ <input type="checkbox"/> Do Not Resuscitate</p> <p>_____ <input type="checkbox"/> Do Not Hospitalize</p> <p>_____ <input type="checkbox"/> POLST/MOLST; POST/MOST</p> <p>_____ <input type="checkbox"/> Organ Donation</p> <p>_____ <input type="checkbox"/> Autopsy Request</p> <p>_____ <input type="checkbox"/> Other _____</p>	<p>DATE ENACTED</p> <p>_____ <input type="checkbox"/> Medication Restrictions specify _____</p> <p>_____ <input type="checkbox"/> Other Treatment Restrictions</p> <p>_____ <input type="checkbox"/> Tube Feeding _____</p> <p>_____ <input type="checkbox"/> Intubation/Ventilator</p> <p>_____ <input type="checkbox"/> Other Advance Directives specify below _____</p>
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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 _____ Date _____

Legal Representative _____ Date _____

If Legal Representative Signed, Complete the Following:

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

WHITE - Medical Record **PINK - Resident/Patient/Client**

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