ADVANCE DIRECTIVES/MEDICAL TREATMENT DECISIONS ACKNOWLEDGMENT OF RECEIPT

RESIDENT UNDERSTANDING/ACKNOWLEDGMENT–ADVANCE DIRECTIVE/MEDICAL TREATMENT DECISIONS

❑ I acknowledge that I have been informed orally and 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 decisionally incapable. I understand it is my responsibility to provide copies of all such pertinent documentation to this facility which verify advance directives formulated and/or executed by me for placement in my medical record.

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

X _____ _____

Resident or Resident Representative *Date*

If Resident Representative signed, complete the following:

_____ _____

Print name *Relationship to Resident*

_____ _____

(1) Witness *Date*

_____ _____

(2) Witness (Second witness signature required if acknowledged by resident "mark".) *Date*

_____ _____

Interpreter (if applicable) *Date*

FACILITY ACKNOWLEDGMENT OF RECEIPT–RESIDENT ADVANCE DIRECTIVES

RESIDENT SUPPLIED VERIFICATION	ENACTED		RECEIVED FROM RESIDENT		PLACED IN CHART		LOCATION OF DOCUMENTATION
	DATE	INITIALS	DATE	INITIALS	DATE	INITIALS	
Medical Durable Power of Attorney							
Financial Durable Power of Attorney							
Guardian							
Health Care Proxy							
Do Not Resuscitate (DNR)							
Living Will							
Physician Orders for Life Sustaining Treatment (POLST/MOLST; POST/MOST)							
Intubation/Ventilator							
Organ Donation							
Intravenous Feedings							
Tube Feedings							
Withhold Medications							
Autopsy Request							
No Hospitalization Request							
Other (specify)							

INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE

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

ADVANCE DIRECTIVES/MEDICAL TREATMENT DECISIONS ACKNOWLEDGMENT OF RECEIPT

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X _____ _____

Resident or Resident Representative *Date*

If Resident Representative signed, complete the following:

_____ _____

Print name *Relationship to Resident*

_____ _____

(1) Witness *Date*

_____ _____

(2) Witness (Second witness signature required if acknowledged by resident "mark".) *Date*

_____ _____

Interpreter (if applicable) *Date*