



Advance Directive Medical Record Notation

Patient Name: _____ Patient DOB: _____

			Date	Initials
Has the patient <i>received information</i> regarding Advance Directives?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
Has the patient <i>issued</i> an Advance Directive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
If yes, please specify:	<input type="checkbox"/> DNR	Date: ___/___/___		
	<input type="checkbox"/> Health Care Proxy	Date: ___/___/___		
	<input type="checkbox"/> Living Will	Date: ___/___/___		
If yes, is copy in the medical record?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
If no, have you readdressed Advance Directives with this patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____

Comments:

