

**Name:** ­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date**: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_

**Date of Birth:** ­­\_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_

Do you have an **Advance Directive/ Living Will**? **YES NO**

Do you have a **Durable Medical Power of Attorney**? **YES NO**

Do you have an **Appointed Healthcare Representative** **to** **YES NO**

**make decisions for you in the event you are not able to**?

Do you have a **MOLST (Medical Orders for Life-Sustaining Treatment)** **YES NO**

**or POLST (Practitioner Orders for Life-Sustaining Treatment) form completed?**

**-------------------------------------------------------------------------------------------------------------------------------**

**If you answered “YES” to any of the above questions**, please provide us with a copy of the Advanced Directive/Living Will, Healthcare Proxy or Power or Attorney, MOLST or POLST form, as applicable, to be included in your medical record. We will provide a stamped, self-addressed envelope, if needed, for your convenience.

**If you answered “NO” to any the above questions**, would you like more information regarding the documents listed above?

**YES NO**

Indicate which you would like to know more about:

**Adv. Dir./Living Wills Power of Attorney Healthcare Proxy MOLST/POLST**

(Medical/Practitioner Orders for Life -Sustaining treatment)

Would you like to have a conversation with your Practitioner about **Advance Directives/Living Wills**, **Durable Power of Attorney, Healthcare Proxy** or **MOLST/POLST?**

* **Yes-** schedule for a future visit
* **No-** I do not want to have this conversation

If you answered “**YES**” to having a conversation with your physician and would like another person to be present, please provide their name and relationship to you:

**If Yes- Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**