Texas Center for Infectious Disease

Advance Directive Admission Form and Checklist

Your answers to the following questions will assist your Physician and the Hospital to respect your wishes regarding your medical care. This information will become a part of your medical record.

				PATIENT'S INITIALS
1.	Have you been provided with a copy of the information called *"Patient Rights Regarding Health Care Decision"*?	____YES	_____NO	_____
2.	Have you prepared a "*Living Will*"? *If yes, please provide the Hospital with a copy for your medical record.	_____YES	_____NO	_____
3.	Have you prepared a *Durable Power of Attorney* for Health Care? * If yes, please provide the Hospital with a copy for your medical record.	_____YES	_____NO	_____
4.	Have you provided this facility with an *Advance Directive* on a prior admission and is it still in effect? * If yes, Admitting Office to contact Medical Records to obtain a copy for the medical record.	____YES	_____NO	_____
5.	Do you desire to execute a *Living Will/Durable Power of Attorney*? * If yes, refer to in order: a. Physician b. Social Service c. Volunteer Service	_____YES	_____NO	_____

OVER

HOSPITAL STAFF DIRECTIONS: ***Check when each step is completed.***

1. _____ Verify the above questions where answered and actions taken where required.

2. _____ If the "*Patient Rights*" information was provided to someone other than the patient, complete the following:

Reason information was given to someone other than the patient:

_____

_____

_____

_____ _____

Name of Individual Receiving Information **Relationship to Patient**

3. _____ If information was provided in a language other than English, specify language and method.

4. _____ Verify patient was advised on how to obtain additional information on Advance Directives.

5. _____ Verify the Patient/Family Member/Legal Representative was asked to provide the Hospital with a copy of the Advanced Directive which will be retained in the medical record.

File this form on the medical record and give a copy to the patient.

_____ _____

Name of Patient **Name of Individual giving information if different from Patient**

_____

Signature of Patient

_____

Signature of Hospital Representative