ADVANCE DIRECTIVE ACKNOWLEDGEMENT

Resident Name _____ Attending Physician _____

This facility has developed a program to inform residents and families of the various means of ensuring that resident desires are identified and fulfilled in deciding how to deal with cases involving refusal of medical treatment. Residents and families are fully informed on the availability of options of giving all medical care providers advance directive regarding the resident's health care decisions. Residents are not required to have prior advance directive or initiate preferred intensity of care instructions if you do not wish to do so.

Please read and initial the following statements:

1. _____ I/We have been given written materials about my right to accept or refuse medical treatments.
2. _____ I/We have been informed of my rights to formulate an Advance Directive.
3. _____ I/We understand that I am not required to have an Advance Directive in order to receive medical treatment at this facility.
4. _____ I/We understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

☐ I have executed an Advance Directive	☐ Durable Power of Attorney for Health ☐ Natural Death Act ☐ Living Will
☐ I have not executed an Advance Directive	☐ Other_____

PREFERRED INTENSITY OF CARE AUTHORIZATION / DECISIONS

Preferred intensity authorizations are given after the physician for the resident has advised the undersigned as to the specific condition of the resident, benefits of the medical care described and the resident outcome of withholding that medical care explained. If an emergency exists where there is an anticipated condition in which immediate action is necessary to prevent serious disability or alleviate severe physical pain, you will be contacted and action taken in accordance with physician orders.

CARDIO-PULMONARY RESUSCITATION: ☐ YES ☐ NO HOSPITALIZATION: ☐ YES ☐ NO
INTRAVENOUS FLUIDS: ☐ YES ☐ NO TUBE FEEDING ☐ YES ☐ NO
MEDICATION RESTRICTION: ☐ YES, SPECIFY_____
☐ NO
TREATMENT RESTRICTION: ☐ YES, SPECIFY_____
☐ NO
OTHER DIRECTIVE/REQUESTS:_____

☐ Resident is capable of making preferred intensity decisions.

_____ Date_____
Resident's Signature

☐ Resident is not capable of making preferred intensity of care decisions and I/we request that the withholding of the above described medical care is consistent with the views of the resident.

_____ _____
Surrogate Decision Maker-Relationship/Date Surrogate Decision Maker-Relationship/Date

Facility Representative/Title_____ Date_____
Physician Signature_____ Date_____

White – Medical Records Yellow – Resident's Copy