

Pearl's Promise LLC

ADVANCE DIRECTIVE CHECKLIST FORM

Please read the following three (3) statements. Please initial each statement.

1. I have been given written materials on my rights to accept or refuse medical and surgical treatment and my rights to formulate advance directives. \_\_\_\_\_(Client Initials)
  
2. I understand that I am not required to have an advance directive to receive medical treatment. \_\_\_\_\_(Client Initials)
  
3. I understand that the terms of any advance directive that I executed will be followed by this agency to the extent permitted by law and in accordance with the facilities or service's policies and procedures. \_\_\_\_\_(Client Initials)

Please check one of the following statements:

I have executed an advance directive and am providing the agency with a copy at this time.

I have executed an advance directive and will provide a copy to the agency or services.

I understand that the staff will not be able to follow the terms of my advance directive until I provide a copy of it to the staff.

I have not executed an advance directive and do not wish to discuss advance directives further at this time.

I have not executed an advance directive but would like to obtain more information.

I have not executed an advance directive, but I am ready to complete the document and request Assistance to do so.

Patient unable to communicate. Written materials given to family.

Patient unable to communicate. No family available. Written material sent with medical record.

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(Resident Signature)

Date:

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(Resident Representative Signature)

Date: