MRN #_____

RCCA®
REGIONAL CANCER CARE ASSOCIATES

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 make decisions for you in the event you are not able to**? **YES** **NO**

Do you have a **MOLST (Medical Orders for Life-Sustaining Treatment) or POLST (Practitioner Orders for Life-Sustaining Treatment) form completed?** **YES** **NO**

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:** _____