MRN #_____

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 of 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:

Advance Directives/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: _____