Huntington Family Medicine

50 Bellefontaine St Suite #403

Pasadena, CA 91105

**ADVANCE DIRECTIVE STATUS**

I have been informed of my right to formulate an Advance Directive and I have been provided

with information regarding the execution of an Advance Directive.

Please check one of the following:

[ ] I have previously completed an Advance Directive and have provided a copy for inclusion in my records.

[ ] A copy of my Advance Directive is on file with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Physician or health care facility)

[ ] I have not executed an Advance Directive and I am not interested in any further information.

[ ] I am interested in the formulation of an Advance Directive and will discuss my options with my primary care provider.

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Patient’s Signature Date

Comments:

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[ ] The patient was given a brochure/information on Advance Directives.

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Practitioner and/or Staff’s Signature Date

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| --- | --- |
| Patient Name: | DOB: |