Please align Patient Label with bottom line for auto filing.

University Health System

Advance Directives Information

Providing you with excellent health care is not only our mission and commitment, it is our primary purpose. Our focus is on your individual health care needs and our goal is to respect your dignity and choices. Every patient receives equal attention and equal access to all of our services. Care is provided in a compassionate manner that is free from discrimination based on race, religion, age, gender, sexual orientation, gender identity, disability or economic status.

"Advance Directives" are written, legal documents that describe your wishes about your future health care. They can provide your loved ones and health care providers with instructions on how to best care for you if you are unable to communicate. Types of advance directive documents include Medical Power of Attorney, Directive to Physicians, and Out-of-Hospital Do Not Resuscitate orders.

If you have any questions about Advance Directives, there are multiple resources available to assist you in providing answers. You can discuss Advance Directives with the physicians treating you, your nurses, patient access staff, and/or your social worker. You are also encouraged to discuss Advance Directives with your personal physician, your religious advisor, and/or your lawyer, if you have one. If you would like additional information about Advance Directives, beyond what has been provided today, please visit the University Health System website at: http://www.universityhealthsystem.com/patients/support/advanced-directives

The information in this form is provided to you to ensure that you understand what an Advance Directive is and to inform you that you have the **right** to additional information including the right to execute an Advance Directive during your care at University Health System.

Patient has an Advance Directive? Yes ☐ No ☐

IF YES, ONE OF THE FOLLOWING MUST BE COMPLETED:

☐ A Copy of the Advance Directive(s) is provided and scanned into the EMR

☐ I have an Advance Directive(s) but I do not have it with me

IF NO, ONE OF THE FOLLOWING MUST BE COMPLETED:

☐ I do not wish to receive more information about Advance Directives

☐ I wish to receive more information about Advance Directives

I have fully read this **Advance Directive Information** and I fully understand its contents. If I requested more information about Advance Directives, it was provided to me. I am signing this freely and voluntarily.

Signature of Patient OR Legally Responsible Person	Relationship, IF not Patient	Date	Time

Witness Signature	Date	Time

If Applicable, Name and ID# of Interpreter_____Language Translated: _____