

ADVANCE DIRECTIVE CHECKLIST

Client able to give or receive information?

Yes CSH 170, Your Right to Decide, given: Date/Time/Employee

Signature/Title _____

No Date/Time/ Employee Signature/Title _____

_____ If client is a minor or has a legal guardian, so note and no further documentation is necessary. If client is initially unable to give or receive information, document follow up efforts with employee signature/title and date/time (continue on reverse if more space is needed):

Client has:

Living Will Copy Filed in Special Request (CSH-650) sleeve: Date _____ Time _____

Specific instructions if any re: nutrition &/or hydration:

_____ If copy not initially available, document efforts to get copy with employee signature/title and date/time:

Durable Power of Attorney for Healthcare Copy Filed in Special Request (CSH-650) sleeve: Date _____ Time _____

Name of Agent _____ Telephone Number(s) _____

Address _____

_____ If copy not initially available, document efforts to get copy with employee signature/title and date/time:

Other Directives, if any, described below and/or filed in Special Request (CSH-650) sleeve:

No Advance Directive

Client: Please read the following statements:

1. I have been given written materials on my rights to accept or refuse medical and surgical treatment and my right to formulate advance directives. I have been informed of my rights and options under Georgia law concerning the making of treatment decisions and the formation of advance directives such as a Living Will or Healthcare Power of Attorney.
2. I understand that I am not required to have an advance directive in order to receive medical treatment at Central State Hospital.
3. I understand that the terms of any advance directive that I execute will be followed to the extent possible under the law by Central State Hospital.

Client's Signature/Date/Time

Employee's Signature/Date/Time

Client Identification