

OPTIONAL ORAL ADVANCE DIRECTIVE FORM

Use this form if the Resident has expressed health care wishes and is unable to document them using a written advance directive. Place completed document in the Resident's medical record.

1. Resident's Name:

2. Resident's Date of Birth:

3. Resident's Diagnosis:

4. Appointment of a Health Care Agent (Name, Address and Telephone Number):

If not present, how was the Agent informed of the Resident's wishes? _____

5. Medical Procedure To Be Performed (If possible, quote the Resident's exact words):

6. Medical Procedure To Be Withheld or Withdrawn (using Resident's exact words if possible):

7. Witnesses to the Oral Advance Directive:

I certify that the Resident made expressed the above wishes in my presence concerning their health care, and including any life-sustaining treatment noted.

Date: _____

Signature of Attending Physician or Nurse
Practitioner

Date: _____

Signature of Witness