CHOICE Health Plans

ADVANCED CARE PLANNING

Name:	
Date:	ID#:

EDUCATION

Education provided: ☐ Yes ☐ No ☐ Patient refused ☐ Other: ______________

Reviewed: ☐ Health Care Proxy ☐ Living Will ☐ DNR ☐ DNI ☐ N/A-refused

TYPE OF ADVANCED CARE PLANNING

Patient has the following:	Copy requested	Document received	Comments
☐ None			
☐ Health Care Proxy			
☐ Living Will			
☐ Power of Attorney			
☐ DNR			
☐ DNI			
☐ MOLST			
☐ Five Wishes			
☐ Other:			

Clinician:

DRAFT