**Client Name:**

**\_\_\_\_\_ Client has an Advanced Directive.**

**\_\_\_\_\_I have been advised to give a copy of my Advance Directives to my physician.**

**\_\_\_\_** **I understand that I can make changes to my Advance Directives at any time.**

Copies of the Advanced Directive can be found \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Copies of the Advanced Directive have been given to

(Name)

and \_\_\_

\_\_\_\_\_ Client **has does not have** a Power of Attorney or Health Care Proxy.

\_\_\_\_\_ Medical decision making authority has been given by **Power of Attorney** to:

\_\_\_\_\_\_\_\_. \_\_\_/

 Name Relationship Phone number

\_\_\_\_ *A copy of the Power of Attorney document is attached*

**\_\_\_\_\_\_\_ Client does NOT have an Advanced Directive.**

**\_\_\_\_\_\_\_ I understand that the home health agency does not require that I develop an**

 **Advanced Directive in order to receive care.**

**\_\_\_\_\_\_\_ Federal and state laws regarding Advance Directives have been explained**

 **and materials have been provided about these laws by the Nursing Supervisor.**

**Client Signature: X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_**

The Client has given me the responsibility of acting as the *Client Representative*.

I, attest to the above information as being true.

 Name (please print)

***Signature of Client Representative*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_**

Relationship to Client: \_\_\_MOTHER\_\_\_

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_ /\_\_\_\_\_

**(Nurse Signature/Title) (Date)**

Notes: