UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

UCSF Medical Center

ADVANCE HEALTH CARE DIRECTIVE INFORMATION

ADMISSIONS STAFF ☐ **Check appropriate box and sign below.**

LEGEND FOR CODING

AD =	Advance Directive	G =	AD Info Given
Y =	Yes, Pt has AD	W =	AD Info Refused
N =	No. Pt does not have AD	R =	Request SW
A =	AD in Chart	D =	Deferred

☐ Patient provided a copy of his/her advance directive. (Y/A)
Instructions to Staff: Copy Advance Directive and place in patient's medical record behind the Advance Directive divider.

If a copy of the Advance Directive is not in the patient's chart, please call Admitting at 353-1488.

☐ Patient has an advance directive but did not bring a copy to the hospital.*

☐ Patient states, "I do not have an advance directive." *

Instructions to Staff:* If either of the two boxes above with an asterisk (*) is checked, you **must complete one of the following:

☐ Advance directive information given. No request for intervention at this time. (N/G)

☐ Advance directive information refused. (N/W)

☐ Patient would like to provide an oral AD to the attending physician. (N/R)
Instructions to Staff: Please inform attending physician via phone or pager.
An oral advance directive is valid only during this hospitalization or for 60 days, whichever period is shorter.

Dr. _____ informed of request on _____ at _____ .
(Print attending physician name) (date) (time)

☐ Patient would like to complete an advance directive while in the hospital. (N/R)
Instructions to Staff: Please contact Social Work at 353-1504.

☐ SW Dept. informed of request. Contact name: _____
Note: AD status may change after SW intervention. See Social Worker box below.

☐ Patient is unable to answer questions about advance directives. (N/D)
Indicate reason (must be clinical, and one that will not allow the patient to communicate prior to discharge)

_____

Signature of Staff completing this form _____ **Date:** ____ /____ /____

Print Name: _____

SOCIAL WORKER ☐ **Check appropriate boxes and sign below.**

To be completed by Social Worker interviewing the patient. Indicate change in AD status below.

☐ Advance Directive completed and placed in patient's medical record chart. (Y/A)
☐ Healthcare providers notified and progress note written.

☐ Assistance provided but advance directive not completed. (N/G)

Social Worker's Signature: _____ Date: ____ /____ /____

Print Name: _____

Comments: _____

_____

If you have any questions regarding this form, please contact Social Work at 353-1504.

ATTENDING PHYSICIAN ☐ **Check box below and complete the back of this form.**

☐ **Oral Advance Directive completed.** (Y/A) See back of this form for details. →

876-055 (Rev. 05/04) RELIZON MEDICAL RECORD COPY

UCSF Medical Center

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DOCUMENTATION OF ORAL ADVANCE HEALTH CARE DIRECTIVES

(If requested by patient)

Name of Health Care Agent designated by patient: _____

Address: _____

Phone number: _____ Relationship to Patient: _____

Alternate Agent (if desired): _____

Address: _____

Phone number: _____ Relationship to Patient: _____

General directive (if known, but not necessary): _____

_____

_____

_____

_____

_____

Attending Physician's Name (Print): _____

Attending Physician's Signature: _____

Attending Physician's License Number: _____ Date: _____

Instructions to Staff: Upon completion, please file in the Advance Directives section of the patient's medical chart

This oral advance directive is valid only during this hospitalization or for 60 days, whichever period is shorter.

☐ Oral AD Revoked by Patient

Signature: _____ Date: _____

Attending Physician receiving the information

Print Name: _____

Instructions: **Place an (X) through the Oral AD Document.**

Instructions to Staff: **Notify Admissions of the revocation at 353-1488. Please file this form in Advance Directive section of the patient's medical chart.**