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PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

NAME: _____

SSN: _____ DATE OF BIRTH: _____

1. I have been given information about Advance Directives.	YES	NO
2. I have executed a Living Will.	YES	NO
3. I have appointed a Health Care Surrogate.	YES	NO
4. I am providing/I will provide my primary care physician a current copy of my Advance Directive.	YES	NO

_____ _____
Signature Date

If other than patient, specify relationship to patient: _____