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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: _____