DODGE COUNTY HOSPITAL
Eastman, Georgia

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

Patient ID Stamp

Name: _____

Date of Birth: _____Identification: #_____

PLEASE INITIAL ONE (1) OF THE FOLLOWING STATEMENTS:

1) ☐ I have an advance directive with me and wish for it to be followed

2) ☐ I have an advance directive but do not have it with me. I have updated the copy the hospital has and wish for it to be followed.

3) ☐ I have an advance directive but do not have it with me. I will make arrangement for a copy to be brought to the hospital as soon as possible. In the meantime, my wishes are as follows:

_____
_____
_____

_____ _____
Signature of Patient Date

_____ _____
Witness Signature Date

4) ☐ I DO NOT have an Advance Directive, but would like more information. My wishes are:

_____
_____
_____

_____ _____
Signature of Patient Witness Date

5) ☐ I DO NOT have an advance directive and DO NOT want further information.

_____ _____
Signature of Patient Witness Date

Revised January 13, 2006