ADVANCE DIRECTIVE

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Dear Patient,

The office of Lavinia K. Chong, M.D., Inc. would like to know your wishes for your medical care during this admission. An **Advance Directive** allows you to instruct your physician on medical decisions if your condition worsens and you are no longer able to communicate with your health care provider(s). **It is our office policy to not honor "Do Not Resuscitate" directives.**

The office does not require you to have an Advance Directive and the staff cannot assist you in making these decisions. We encourage you to include your family, your spiritual advisors and your physician in helping you to make your advance health care decisions.

Please take a moment and check the statements that most accurately reflect your wishes should you not be able to tell your physician.

_____I DO have an existing Advance Directive, and will provide the office with a copy today.

_____I DO have an existing Advance Directive but do not have a copy with me today. Until I provide the office with a copy, I choose the option below for my **temporary** advance directive.

_____I do NOT have an existing Advance Directive. Therefore, for this admission only, I choose the following option for my **temporary** advance directive. I will make my family aware of my wishes.

Option #1

_____In the event I am no longer able to communicate my wishes to my physician, I choose the following person to make my health care decisions for me:

Name _____ Phone _____

Relationship _____

Option #2

_____If my condition should worsen and I am no longer able to communicate my wishes to my physician, **I DO NOT WISH** to have any treatment to prolong my life, if my physician agrees that I am unlikely to recover or if the burden of the care and treatment outweigh the benefits.

Option #3

_____If my condition should worsen and I am no longer able to communicate my wishes to my physician, **I DO NOT WISH** to have my life prolonged by the use of resuscitation and other life support measures within the limits of generally accepted health care standards.

Option #4

_____My wishes are: _____

_____

_____

_____ _____

[Patient's signature only] [Date]

Please provide the name and phone number of your Primary Care Physician:

Name_____ Phone_____