## UNIVERSITY MEDICAL CENTER

## PHYSICIANS ORDERS AND TREATMENTS

(ADVANCE DIRECTIVE)

MD Hour Date of of Order Order	Nurse's Signature	NURSE: PLEASE X IN COLUMN ON LINE, FOR MEDICATIONS REQUIRED FROM PHARMACY PHYSICIAN MUST ENTER DATE, HOUR, AND SIGN EACH SET OF ORDERS.
		PLEASE USE THIS ORDER SHEET ONLY TO WRITE ORDERS ASSOCI- ATED WITH YOUR PATIENT'S ADVANCE DIRECTIVE (LIVING WILL) WHEN APPLICABLE.
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University Medical Center

PHYSICIANS ORDERS AND TREATMENTS

(ADVANCE DIRECTIVE)

## **UNIVERSITY MEDICAL CENTER**

## **PROGRESS RECORD**

(ADVANCE DIRECTIVE)

Date   Note progress in case, complications, change in diagnosis, condition related to the advance directive   Date									
HOSPITAL (OR THEIR APPROPRIATE HEALTH CARE REPRESENTATIVE) WHETHER OR NOT THEY HAVE AN ADVANCE DIRECTIVE (LIVING WILL). PLEASE USE THIS PROGRESS SHEET TO DOCUMENT THAT DISCUSSION.  I am aware that an advance directive exists. I have discussed the terms of the document with my patient. The document is present in the Medical Record.  I am aware that an advance directive exists. The document is NOT available. I have documented the patient's wishes below.  I have confirmed that my patient does not have an advance directive.  I did not discuss the issue of an Advance Directive with my patient because it was contraindicated during this admission.  Name of the patient's Health Care Representative (if applicable)  Name	Date			Date					
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Name Relationship Physician's Signature Date			e v	vith my	patient because it was contraindicated				
Physician's Signature Date	Name of t	he patient's Health Care Representative (if appl	ica	ble)					
	Name	Name Relationship							
	Physician'	s Signature			Date				
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