ADVANCE DIRECTIVES

Patient name: _____ **Date**:_____

Please read the following important information

The Georgia State Legislature understands that it is important for us to make our own decisions about medical care even when we become unable to make or communicate decisions. This decision is best considered when we are well. The Georgia Legislature has provided a way to indicate our wishes called the **Georgia Advance Directive for Health Care.** We will be happy to provide you with a sample of the Georgia Advance Directive for Health Care form upon your request. In addition, your nurse and physician are available to discuss any information, questions, or concerns you may have about Advance Directives.

As a new patient to Georgia Cancer Specialists affiliated with Northside Hospital Cancer Institute, our staff will ask you whether you have signed an Advance Directive. Your response on this form will be recorded in your medical record. If you have already signed legal documents that explain your Advance Directives, our staff will request a copy of the documents for your medical record. These documents will help your family and our staffs to make sure that your wishes are carried out in the event of a sudden problem, which prevents you from expressing your wishes at that time.

Of course, your decision to sign an Advance Directive will in no way change the care that anyone at Georgia Cancer Specialists affiliated with Northside Hospital Cancer Institute provides to you and your family.

Please indicate your current choice regarding Advance Directives:

____ I **have signed** an Advance Directive and **will provide a copy** to Georgia Cancer Specialists affiliated with Northside Hospital Cancer Institute. I understand that staff or physicians will not be able to follow the terms of my Advance Directive until I provide them with a copy of the legal document.

____ I have **not** signed an Advance Directive, but **would like** additional information.

____ I have **not** signed an Advance Directive and **do not** wish further information at this time.

_____ _____

Patient Signature **Date**

Created: 08/28/00
Revised: 2013