



MR# _____ Acct# _____
 DOB _____ Sex _____ Age _____

ADVANCED DIRECTIVE / ORGAN DONATION INTERVIEW

Section A: Patient Registration Completes (For Inpatients / Outpatients 18 years and Older)

1. Does this patient have an Organ Donor card or driver's license denoting Organ Donor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. If YES, copy of driver's license or organ donor card is scanned?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Signature of person assessing organ donor status _____	Date _____	Time _____

Section B: Admitting Nurse Completes (For Inpatients 18 years and Older)

1. Does the patient have an Advance Directive?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
a. If they have AD with them, is copy placed on chart?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. If no copy with patient – consult placed to Case Management by nurse	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. If patient does not have Advance Directive, do they want information about Advance Directive?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
a. If YES to #2, Advance Directive Booklet provided and video on demand	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Signature of person assessing advance directive status _____	Date _____	Time _____

I have been informed that the presence or absence of an Advance Directive will in no way alter any care rendered to me at Inspira Medical Centers, Inc., and that policies on advance directives are available for review upon request.

 Signature Date and Time of patient (if unable to sign -next of kin)

 Witness signature and date and time

Section C: Case Management Completes (Case Manager or Social Worker)

1: Valid Advance Directive

1. Advance Directive reviewed for validity, appropriate witnesses , signature and date <input type="checkbox"/> Witnesses could be notary, attorney – only need one <input type="checkbox"/> Witnesses could be adult (>18) witnesses other than health care rep or physician and (need two – Social Worker and Case Manager may be used)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Document validity by recording “verified” on copy with signature, date and time	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Copy placed in AD section of chart	<input type="checkbox"/> YES	<input type="checkbox"/> NO

2: Invalid Advance Directive

1. Reviewed problems of invalid Advance Directive with patient	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Patient creates a new Advance Directive, complete box “New Advance Directive Created”	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Unable to create new AD. See CM Note: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

3: New Advance Directive Created

1. Assisted Patient with completing valid or new Advance Directive	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Copy placed in AD section of chart	<input type="checkbox"/> YES	<input type="checkbox"/> NO

4: No Advance Directive exists. Information provided.

1. Patient confirms that they do not have an Advance Directive	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Patient provided with information on Advance Directive	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Patient confirms that they do not want to create an Advance Directive at this time	<input type="checkbox"/> YES	<input type="checkbox"/> NO

5: Advance Directive Follow Up (Unavailable)

1. Patient/Family states that someone will bring in Advance Directive from home 1st Attempt: DATE: _____ TIME _____ 2nd Attempt: DATE: _____ TIME _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Copy of AD brought in. DATE: _____ TIME _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Copy of AD brought in. Complete box “Valid Advance Directive” or “Invalid Advance Directive”	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Unable to confirm Existence	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Signature of person assessing presence of Advance Directive _____	Date _____	Time _____