PATIENT SELF DETERMINATION QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act (OBRA) of 1990 and Chapter 765 of the Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

☐ I have made such a declaration

☐ I have **NOT** made such a declaration

Health Care Surrogate

☐ I have designated a Health Care Surrogate

☐ I have **NOT** designated a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions.

☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

_____ _____ - _____ - _____

Please Print Full Name Social Security Number

Signature: _____ Date:_____

Patient or Patient Representative

Relationship of Patient Representative (If applicable) :_____

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

_____	_____
Signature of Patient or Patient Rep Date	Signature of Patient or Patient Rep. Date
_____	_____
Signature of Patient or Patient Rep Date	Signature of Patient or Patient Rep Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Patient Rep:_____ Date:_____

Relationship of Patient Representative (If applicable):_____