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**NAVAL HOSPITAL CAMP PENDLETON ADVANCE DIRECTIVES  
QUESTIONNAIRE**

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**TO BE COMPLETED BY ADULT PATIENTS**

Check all boxes that apply.

I have the following Advance Directive:

- A written Health Care Directive (Living Will) and wish to have a copy included in my medical record for the physician to act upon. My Health Care Agent for these purposes is \_\_\_\_\_  
A current copy is located at \_\_\_\_\_
- A Durable Power of Attorney for Health Care, or other advance directive identifying a health care agent, and wish to have a copy included in my medical record for my physician to act upon. My Health Care Agent for these purposes is \_\_\_\_\_  
A current copy is located at \_\_\_\_\_

I do not have a written Advance Directive and:

- I request further information regarding advance directives.
- I do not desire any information at this time.

I acknowledge having received written information about Naval Hospital Camp Pendleton's policies regarding my rights to accept or refuse medical treatment and to formulate advance directives. I understand that the formulation of an advance directive is a personal decision and is not required as a condition for treatment at this medical treatment facility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**THIS SECTION FOR USE BY HOSPITAL STAFF**

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Please provide the following information. Check all boxes that apply.

- ADVANCE DIRECTIVE INFORMATION GIVEN TO THE PATIENT.
- ADVANCE DIRECTIVE INFORMATION NOT GIVEN TO THE PATIENT. (STATE REASON \_\_\_\_\_)
- COPY OF PATIENT'S ADVANCE DIRECTIVE RECEIVED BY ADMISSION CLERK.

Signature of Clinic/Admissions Clerk: \_\_\_\_\_ Date: \_\_\_\_\_

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ADDRESSOGRAPH

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