

**NOTICE OF
ADVANCE DIRECTIVE ACTIVATION**

(a licensed physician or mental health professional must complete this form)

Patient Name: _____ Medical Record #: _____

Date: _____

Following appropriate evaluation and/or discussion with the above-named patient, the following has been determined: *(initial only one)*

_____ This patient is *now* unable to adequately comprehend his/her medical condition and/or is unable to provide informed consent for necessary treatment(s).

_____ This patient is *intermittently* unable to comprehend his/her medical condition and/or to provide informed consent for necessary treatment(s). An advance directive agent/proxy is needed on an emergent/stand-by basis.

_____ This patient *has* decisional capacity, but due to the burdens of illness and/or informed consent criteria, he/she *elects to defer* decision-making to his/her agent/proxy as named in a valid advance directive document on file at this medical facility.

Reliance on an advance directive agent is expected to be:

(initial only one)

_____ Temporary. The patient will be continuously reevaluated, and the agent/proxy will be notified if the patient regains decision-making capacity and/or desires to resume a decision-making role.

_____ Permanent. The patient's loss of decision-making capacity is expected to be enduring. Reevaluation of decision-making capacity will take place only if the patient's cognitive condition substantially and unexpectedly changes.

An agent/proxy named in this patient's advance directive has been notified of the above on this date at the following time: _____. He/she has been advised of the patient's overall medical condition, and agrees to remain reasonably available for ongoing consultation and decision-making participation. In the event he/she will not be available, he/she agrees to notify the facility staff and any alternate agent/proxy in advance.

Signed: _____

(Attending physician or other health care provider)

Printed Name: _____ Date: _____

Address _____ Phone _____