

VAIL VALLEY MEDICAL CENTER  
Edwards, Colorado

**Advanced Directives  
Questionnaire**

Please answer the following questions if you are able to do so. The nursing staff will provide assistance if necessary.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Do you have a  
Durable Power of Attorney for Health Care? Yes\_\_\_ No\_\_\_  
Living Will? Yes\_\_\_ No\_\_\_
2. If "yes" to either of the above, please provide us with a copy for you chart.
3. If "no", would you like more information? Yes\_\_\_ No\_\_\_

\_\_\_\_\_  
Signature

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**FOR NURSING STAFF USE:**

XRT#: \_\_\_\_\_

1. Copy of Advanced Directive requested \_\_\_\_\_  
Date  
received \_\_\_\_\_  
Date
2. Information given:
  - a. Your Right to Dignity: Advanced Directives  
(Circle: English Spanish) \_\_\_\_\_  
Date
  - b. DPAHC form \_\_\_\_\_  
Date
  - c. Living Will Form \_\_\_\_\_  
Date
  - d. Referral to: \_\_\_\_\_  
Date

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
RN Signature

\_\_\_\_\_  
Date