Gateway Medical

Advance Directives Form

_____ _____

Patient Name Patient Date of Birth

Do you currently have any of the following advance directives documents?
(Please check all that apply)

❑ South Carolina Health Care Power of Attorney

If checked, please provide the following information:

_____ _____ _____

First Name Last Name Relationship

❑ South Carolina Durable (Statutory) Power of Attorney

If checked, please provide the following information:

_____ _____ _____

First Name Last Name Relationship

❑ South Carolina General (Financial) Power of Attorney

If checked, please provide the following information:

_____ _____ _____

First Name Last Name Relationship

❑ Desire for a Natural Death

❑ Do Not Resuscitate

❑ Other: _____

Do you need additional information regarding advance directives? ❑ Yes ❑ No

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Date

PLEASE NOTE: Our office will need a copy of any advanced directives that you have checked above.

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