

NORFOLK FAMILY MEDICINE  
INFORMATION SHEET  
900 West Norfolk Ave., Ste 100  
Norfolk, NE 68701

**ADVANCE DIRECTIVE  
QUESTIONNAIRE**

**PATIENT:** \_\_\_\_\_

1. Do you have a durable power of attorney for healthcare? Yes \_\_\_ No \_\_\_

If yes, who is it:      Name: \_\_\_\_\_  
                                 Address: \_\_\_\_\_  
                                 \_\_\_\_\_  
                                 Telephone: \_\_\_\_\_

2. Do you have a living will? Yes \_\_\_ No \_\_\_

If no, would you like more information about a living will/durable power of attorney for healthcare? Yes \_\_\_ No \_\_\_

If you do have a living will, do you have a copy with you? Yes \_\_\_ No \_\_\_

(If you do have a living will/durable power of attorney, please provide this office with a copy of your directives)

**This physician's office has asked me about the above information and has offered further information if desired.**

**Patient signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

This information will be contained in your medical record for future reference. If the status of the above information changes for any reason, it is your responsibility to inform us of any changes so that we may have you complete a new Advance Directive Questionnaire.