MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE	**PATIENT RIGHTS AND ADVANCE DIRECTIVE INFORMATION**	OTSG APPROVED (Date)

1. I understand that Landstuhl Regional Medical Center (LRMC) provides Patient Advocates. These representatives are available to insure my rights as a patient, to review any complaints I may have, and when possible, to resolve my complaints. I acknowledge receipt of the Patient Rights Booklet/Flier and the Notice of Privacy Practices (NOPP). **Patient / Guardian Initials** _____

2. I understand that as a patient, I am expected to collaborate with my provider to make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment and to be informed of any consequences. I may also formulate Advance Medical Directives or a Living Will; however, I am not required to have an Advance Medical Directive or Living Willing in order to receive care. **Patient / Guardian Initials** _____

3. I understand that the terms of any Advance Medical Directives or Living Will that I have executed will be followed by LRMC to the extent permitted by law and in accordance with this facility's policies and procedures. I understand that it is my responsibility to provide this facility with a copy of my Advance Medical Directives or Living Will. I further understand that the staff and physicians of LRMC will not be able to follow the terms of my Advance Medical Directives or Living Will until I provide a copy of it to the staff. **Patient / Guardian Initials** _____

4. I understand that I may seek legal advise from my Legal Assistance Office, or a civilian attorney, depending on my eligibility for Legal Assistance and my personal preference **Patient / Guardian Initials** _____

5. Refusal to store valuables at designated hospital security area and instead choose to maintain such valuables on my person or at my bedside, LRMC will not be responsible for loss or damage to these items.

6. I understand that my status as a patient at LRMC is confidential, and I may elect that it be withheld from anyone except authorized persons with a need-to-know. Authorized persons may include Command Staff, MP's, PAD and clinical staff directly involved with my care. I do ____ / I do NOT _____ wish to have my status released.

For (LRMC) employees and family dependents ONLY, would you like a Command Staff visit?
I do _____ / I do NOT _____ wish to have a Command Staff visit. **Patient / Guardian Initials** _____

7.	YES	NO
7a. I have executed an Advance Medical Directive or Living Will for health care.	Patient / Guardian Initials _____	Patient / Guardian Initials _____
7b. If the answer to question **7a** is **YES**, a copy of my Advance Medical Directive or Living Will is provided with this sheet.	Patient / Guardian Initials _____	Patient / Guardian Initials _____

7c. in the absence of my Advance Medical Directive or Living Will, I have outlined my decisions:

_____

_____

I understand the above instructions, and have no questions regarding content.
PATIENT / GUARDIAN SIGNATURE: _____ **DATE:** _____

Patient unable to sign: _____ PAD representative Signature: _____ **DATE**: _____

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION (FOR TYPED OR WRITTEN ENTRIES GIVE: Name-last, First, middle, grade, date, hospital or medical facility)

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES TREATMENT