Advanced Directives

Check ALL that apply:

_____I have a living will. (If yes, please provide a copy).

_____I have a document that I signed that allows another person to make healthcare decisions for me. (If yes, please provide a copy).

If I ever become too sick to make my own healthcare decisions, I give the following person permission to make them for me:

Name: _____

Phone number: _____

If I become so ill that I cannot tell my doctor what I want, and two doctors agree that they cannot make me better, please: **(Check ALL that apply)**

_____ Keep me clean and free from pain.

_____Do NOT use tubes for: _____ breathing ____feeding _____IV fluids.

_____Let my appointed person decide.

_____If my heart stops, do_____ or _____ do not try to restart it.

_____ Do EVERYTHING possible.

_____ I do not wish to complete an advanced directive at this time

Additional instructions:

_____

_____

_____

Printed Name: _____ Date: _____

Signature: _____ Date: _____

Your surrogate may consult with your health care providers and give informed consent to perform medical procedures that the surrogate feels are in your best interest and make health care decisions for you that the surrogate believes that you would have made under the circumstances if you were capable of making such decisions. Your surrogate has access to your clinical records and has the authority to release information and records to appropriate persons to ensure the continuity of your health care. If there is no indication of what you would have chosen, the surrogate may consider what is in your best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

MCR DEPRESSION SCREENING PHQ-9

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "V" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3.Trouble falling or staying asleep, or sleeping too much				
4.Feeling tired or having little energy				
5.Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself				

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				

Name: _____Date:_____
Date of birth: _____

WELLNESS QUESTIONNAIRE

(Please check one of the following)

- Do you use tobacco products? [ ] YES [ ] NO [ ] Former tobacco user
  If yes, for how many years? _____
  How many packs per day? _____
  What type of tobacco products did you use or are you currently using? _____
  i.e. [cigarettes, cigars, pipe, or smokeless tobacco]

- Marital status? _____

- Activity level: [ ] Light [ ] Moderate [ ] Heavy [ ] None
- Type of Activity:_____

- Diet history? [ ] low calorie [ ] low fat [ ] diabetic [ ] low salt [ ] other_____

- Home Environment/safety:
  Smoke detectors in home? [ ] NO [ ] YES
  Carbon monoxide detectors in home? [ ] NO [ ] YES

- Falls in the last year? [ ] NO [ ] YES
  Did the falls result in injury? [ ] NO [ ] YES Number of falls? _____
  Details of fall? _____

- Pool/spa at home? [ ] NO [ ] YES

- Seatbelt use? [ ] NO [ ] YES

- Hearing loss? [ ] NO [ ] YES
  Do you wear hearing aids? [ ] NO [ ] YES

- Are you incontinent with urinary symptoms? [ ] NO [ ] YES

- Do you take Calcium? [ ] NO [ ] YES
- Do you take a Multivitamin? [ ] NO [ ] YES
- Do you take Vitamin D? [ ] NO [ ] YES
- Do you take Folic Acid? [ ] NO [ ] YES

Name: _____Date:_____
Date of birth: _____

- How do you perform the following activities of daily living?

Dressing:	[ ] Independent	[ ] Needs supervision	[ ] Assistance needed
Bathing:	[ ] Independent	[ ] Needs supervision	[ ] Assistance needed
Walking:	[ ] Independent	[ ] Needs supervision	[ ] Assistance needed
Shopping:	[ ] Independent	[ ] Needs supervision	[ ] Assistance needed
Handling finances:	[ ] Independent	[ ] Needs supervision	[ ] Assistance needed
Managing medications:	[ ] Independent	[ ] Needs supervision	[ ] Assistance needed
Housekeeping:	[ ] Independent	[ ] Needs supervision	[ ] Assistance needed
Functional Assessment –	Do you…		
[ ] Walk independently	[ ] Use cane	[ ] Use a walker	[ ] Use a wheelchair

- Are you able/unable to do the following?

Climb stairs:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Exercise:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Get in/out of cars:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Go down stairs:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Go up stairs:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Kneel:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Perform activities of daily living:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Put on socks and shoes:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Walk:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Walk 10 blocks:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Walk an unlimited distance:	[ ] Able	[ ] Not Able	[ ] Finds it difficult
Walk 5-10 blocks:	[ ] Able	[ ] Not Able	[ ] Finds it difficult