Health Care Directive
The Written Gift

Referral Document

Notice to Client: The Written Gift offers services and information that can help you with advance care planning. By signing this form, you are consenting for The Written Gift to contact you regarding advance care planning. You have the right to revoke this consent via email to thewrittengift@charter.net or via mail to The Written Gift, PO Box 605, Alexandria, MN 56308. They will contact you about advance care planning.

Client Signature: ______________________ Date ______________

Name ______________________ ________ Date ______________________

Location: ______________________ Referred From: ______________

Primary Healthcare Provider: ______________________________

Client Address: ____

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Phone #: ______________________ E-mail address ______________________

Assigned to Facilitator: (Name) ______________________________

on ______________________.

Date(s) of client interaction: ______________________.

Additional notes: ____

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Check all that apply:

- ☐ Information and F/U number given to client and/or family
- ☐ Document completed during facilitation
- ☐ Document reviewed only, F/U appointment made for further discussion as needed
- ☐ Total time spent with client; __________ minutes
- ☐ Client declined meeting after initial referral
- ☐ Follow-up (10 days)*
- ☐ Consent signed

*Follow-up to ensure AD placed in medical records, to healthcare agent, any further questions.

**Please submit this referral form upon completion of the client interaction to The Written Gift via email at thewrittengift@charter.net or mail to The Written Gift, PO Box 605, Alexandria , MN 56308.