Health Care Directive
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: ______________________________________

Gender: ____ Male ____Female _____________ (Short Answer Space) ____ Prefer not to answer

Age: ____ 18-29 ____ 30-39 ____ 40-49 ____ 50-59 ____ 60-69 ____ 70-79 ____ 80-89 ____ 90+ ____ D. Prefer not to answer

Ethnicity: ____ Caucasian/White ____ African-American ____ Latino or Hispanic ____ Asian ____ Native American

____ Native Hawaiian or Pacific Islander ____ Two or More ____

Primary Healthcare Provider: ____

Client Address: ____

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Phone #: ____ E-mail address____________________________________

Referred from/by: ____Contact Info: _________________________________

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

**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.

www.thewrittengift.com

The Written Gift/PYF/6-14-2021
Socials Services-2021/Advanced Care Planning Referral Form