Central Missouri Dermatology Associates, LLP

Patient:_____ **DOB:**_____

MRN #_____

Who is your primary care provider? _____

Please check one that applies to you below:

Influenza(Flu) Vaccine:

___I will receive a flu vaccine this flu season

OR

___I will **NOT** receive a flu vaccine this flu season

Pneumococcal Vaccine(Pneumonia-Age 65 and older):

___I have received the Pneumovax vaccine in the last 5 years

OR

___I have **NOT** received the Pneumovax vaccine in the last 5 years

Advanced Directives:

Advanced directives are designed to respect your wishes regarding future life sustaining medical treatments if you were unable to indicate your wishes. Key interventions and treatment decisions are resuscitation procedures such as Cardiopulmonary Resuscitation(CPR) and mechanical respiration(breathing tube).

Which statement best reflects your wishes:

___I want full CPR to be made

OR

___I do **NOT** want full CPR to be made

___I have a living will

___I have a health care proxy(someone who is legally in charge of my health decisions)

whose name is _____and the contact number is _____.

Patient signature:_____ **Date:**_____