YOLO COUNTY ALCOHOL, DRUG AND MENTAL HEALTH DEPARTMENT

Advance Healthcare Directive

Client Acknowledgement

This information applies to adult clients (ages 18 years and older) only.

Client's Name: _____ **MR No.:** _____

1. Do you have an Advance Healthcare Directive (Advance Directive)? ☐ Yes ☐ No

   a. **IF YES,** have you provided the Yolo County Alcohol, Drug & Mental Health Department (ADMH) with a copy of the Advance Directive? ☐ Yes ☐ No

   b. Date ADMH received client's Advance Directive: _____ Date

2. If ADMH received a copy of your Advance Directive, in the event of an emergency, may ADMH share this Advance Directive with other healthcare providers? ☐ Yes ☐ No

_____ _____

Client's Signature Date

_____ _____

Staff Signature Date