

Who will decide when YOU can't make choices about YOUR own Health Care?

Advance Health Care Directives & POLST

- Deciding about your Own Health Care
- The Advance Healthcare Directive
- Health Care Power of Attorney
- Living Will
- Physician Orders for Life-Sustaining Treatment (POLST)
- Advance Directive Resources

A publication of the



Utah Association for Home Care

1327 South 900 East
Salt Lake City, UT 84105-2301
Phone: (801) 487-8242
Fax: (801) 487-6424

www.ua4hc.org
homecareconnection@msn.com

© Revised 07.08

For Questions regarding your care,
Please Call the Agency
providing services for you.

Your agency phone number!

For **UAHC** Office Use:

Date Order Received _____

Date Order Filled _____

Picked up Delivered Shipped

Payment Received _____

Credit Card Processed _____

Check No. _____ Date _____

Advance Health Care Directive & POLST Pamphlet Order Form



The new Advanced Health Care Directive & POLST pamphlet "Who will decide when YOU can't make choices about YOUR own Health Care?" has been updated to meet the current regulations & guidelines.

Provider and associate members of the Utah Association for Home Care (UAHC) may order the pamphlets at a cost of \$15.00 per unit of 50 pamphlets plus shipping charges. Non-UAHC members may order the pamphlet at a cost of \$30.00 per unit plus shipping charges. ***This form may not be duplicated! We DO encourage you to include your agency telephone number below the box on the front of the pamphlet.***

Three easy ways to order:

Phone..... (801) **487-8242**

Fax.....(801) **487-6424**

E-mail..... homecareconnection@msn.com

Complete this Order Form, make a copy for your files, and return (with your check or credit card information) to:

UAHC

1327 South 900 East
Salt Lake City, Utah 84105

Name _____

Agency _____

Address _____

City _____, UT Zip _____

I would like to order _____ units of 50 pamphlets @

\$ 15.00 per unit (*member*) \$ _____

\$ 30.00 per unit (*non-UAHC*) \$ _____

Priority Shipping & Handling \$ _____

TOTAL PAYMENT DUE: \$

Check Enclosed

Check in Mail

Credit Card

American Express

Discover Card

MasterCard

Visa Exp.Date _____/_____

Credit Card No. _____

Name on Card _____

Signature _____