ADVANCED CARE PLANNING

Patient Name - _____ DOB - _____

This form is intended for you to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy.

Place your initials by only one answer:

_____ I do not want to name a health care proxy at this time.

_____ I would like to discuss advanced care planning with my family and will discuss this further with my doctor at a later date.

_____ I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

First Choice Health Care Proxy Name: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone #: _____ Night-time phone #: _____

Second Choice Health Care Proxy Name: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone #: _____ Night-time phone #: _____

Patient's Signature: _____ Date: _____