

Valley Kidney Specialists, PC  
1230 S. Cedar Crest Blvd, Ste 301  
Allentown, PA 18103



## Advance Care Plan Form

### PATIENT INFORMATION

|   |                                 |
|---|---------------------------------|
| _____                                     | _____                           |
|   | Date                            |
| _____                                     | _____                           |
| Name (Last, first, middle initial)        | Social Security # or Patient ID |
| _____                                     | _____                           |
| Street address, City, ST, ZIP Code        | Physician                       |
| _____                                     | _____                           |
| Primary phone number   Other phone number | Email address                   |

### Please check the appropriate boxes below:

- I have an Advance Care Plan (If you checked this box, please bring a copy of your Advance Care Plan to your next visit).
  - I would like to name a health care agent to make decisions for me in the event that I am unable to make decisions for myself (fill in health care agent information below).
  - I would not like to name a health care agent at this time.
  
- I do NOT have an Advance Care Plan.
  
- I decline to discuss an Advance Care Plan due to my spiritual/cultural beliefs.

### Designated Health Care Agent Information

|   |
|---|
| _____                                     |
| Name (Last, first, middle initial)        |
| _____                                     |
| Street address, City, ST, ZIP Code        |
| _____                                     |
| Primary phone number   Other phone number |

### Patient Signature

|           |       |
|-----------|-------|
| _____     | _____ |
| Signature | Date  |

