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