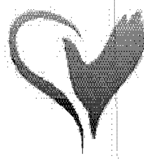

MIAMI BONE & JOINT INSTITUTE

Patient's Acct. #: ____________

ADVANCE CARE PLAN

Patient's Name: ____

(First Name) (Last name)

Patient's address: ____

____________ ____________ ____________

(City) (State) (Zip code)

Has a Medical Enduring Power of Attorney? **Yes / No**

His/Her Name: ____________________ Alternate Name: ____________________

Contact Number (s): ____________________ Contact Number (s): ____________________

____________________ ____________________

My Requests: **(Initial ONE box which best describes your wishes)**

○ In the event of sudden or significant deterioration in my health I request to be transferred to hospital for assessment and treatment.

○ I would like all decisions about medical treatments to be made by my doctors and those I have listed below. I request that they consider my wishes as outlined in this Advance Care Plan.

○ I Decline

Declaration by competent person:

I ask if possible my surrogate decision maker include the following people in discussion and decision about my healthcare:

1. ____________________ 2. ____________________

____________________ ____________________

____________________ ____________________

I, ____________________
Declare that the information completed above
Is true record of my wishes on this date.

Witness Name: ____________________

Witness Signature: ____________________

Signature: ____________________
Date: ____________________

Relationship: ____________________
Date: ____________________