HEALTH CARE SURROGATE APPOINTMENT

1. I, _____, understand that the attending physician of _____ and another physician have agreed that _____ lacks the capacity to make health care decisions or provide informed consent.

2. To the best of my knowledge, _____, has not executed an advance directive, or designated a health care surrogate (or designated health care surrogate is unwilling or unable to act).

3. I am not employed by or associated with the health care facility.

4. I am:

   ☐ **a) A judicially appointed guardian with authority to make health care decisions for the ward.**

   ☐ **b) The patient's spouse.**

   ☐ **c) An adult child of the patient (if the patient has more than one adult child, the persons signing below constitute a majority of the adult children reasonable available for consultation).**

   ☐ **d) The father or mother of the patient.**

   ☐ **e) The adult sibling of the patient. (If the patient has more than one sibling, the persons signing below constitute a majority of the adult siblings who are reasonably available for consultation).**

   ☐ **f) An adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient activities, health, and religious or moral beliefs.**

   To the best of my knowledge, there is no one in a category above me.

5. I understand that as a health care surrogate I shall:

   a) Unless the designation provides otherwise, have final authority to act for the patient and to make care decisions for the patient in matters regarding the patient health care during the patient incapacity.

b) **Expeditiously consult with appropriate health care providers to provide informed consent and make health care decisions for the patient, which I believe the patient would have made under the circumstances if the patient were capable of making such decisions.**

c) **Apply for public benefits, such a Medicare and Medicaid, for the patient and have access to information regarding the patient's income and assets to the extent required to make application. A health care provider may not, however, make such application a condition of continued care if the patient, if capable would have refused to apply.**

d) **I may authorize the release of information and clinical records to appropriate persons to insure the continuity of the patient's health care and the transfer and admission of the patient to or from a health care facility.**

6. I understand that I may not provide consent for:

a) **Abortion**

b) **Sterilization**

c) **Electroshock therapy**

d) **Psychosurgery**

e) **Experimental treatments or therapies, except as recommended by federally approved institutional review boards in accordance with 45 C.F.R., part 46.**

f) **Voluntary admission to a mental health facility.**

7. I understand that any health care decision I make must be based on my informed consent and on the decision I reasonably believe the patient would have made under the circumstances. Any decision to withhold or withdraw life-prolonging procedures must be supported by clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent.

I have read and understand the above and agree to my designation as health care surrogate.

Signature of Surrogate	**Print Name**	**Date**
Signature of Witness	**Print Name**	**Date**
Signature of Witness	**Print Name**	**Date**