Patient Care Preferences Statement

Date: [Insert Date]

To Whom It May Concern,

I, [Patient's Name], born on [Date of Birth], residing at [Address], hereby express my preferences regarding my healthcare and treatment. It is my intention to ensure that my wishes are respected and followed in the event I am unable to communicate them.

Healthcare Preferences

- I prefer to receive care that prioritizes my quality of life.
- I would like to avoid any aggressive life-sustaining treatments if my condition is terminal.
- I wish to receive pain management and palliative care to ensure my comfort.

Preferred Healthcare Providers

In the event of my incapacitation, I wish for my care to be managed by the following healthcare providers:

1. [Provider's Name, Contact Information]
2. [Provider's Name, Contact Information]

Emergency Contact

For any urgent matters regarding my health, please contact:

[Emergency Contact Name, Relationship, Contact Information]

Additional Instructions

If I am unable to make decisions for myself, I empower the following individual to make healthcare decisions on my behalf:

[Name, Relationship, Contact Information]

Thank you for respecting my wishes and ensuring that my healthcare preferences are honored.

Sincerely,

[Patient's Signature]
[Patient's Name]