Advanced Care Planning Preferences

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], wish to outline my advanced care planning preferences regarding my medical treatment and care in the event that I am unable to communicate my wishes.

Healthcare Proxy

I designate [Proxy Name] as my healthcare proxy, who will make decisions on my behalf if I am unable to do so. Contact information for my proxy is as follows:

Phone: [Proxy Phone Number]

Email: [Proxy Email Address]

Medical Treatment Preferences

If I am diagnosed with a terminal condition or am in a persistent vegetative state, I have the following preferences regarding my medical treatment:

- Resuscitation: [Yes/No]
- Mechanical Ventilation: [Yes/No]
- Tube Feeding: [Yes/No]
- Pain Management Options: [Brief Description]

Other Wishes

Additionally, I wish for the following to be considered:

- [Any specific wishes or instructions]

Thank you for respecting my wishes and ensuring that my preferences are followed. This letter should be kept with my medical records.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Address]

[Your Phone Number]