Advanced Care Planning Consent Form

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

Healthcare Provider: ______________________

Introduction

This form is intended to assist in advanced care planning for future medical decisions. By signing this document, you are indicating that you understand the information provided and consent to the outlined plans.

Patient Preferences

Please indicate your preferences regarding medical interventions:

- Life-sustaining treatment
- Resuscitation
- Palliative care
- Organ donation

Designated Healthcare Proxy

Name of Proxy: ______________________

Relationship to Patient: ______________________

Contact Number: ______________________

Consent Statement

I, the undersigned, consent to the above-stated advanced care planning preferences.

Signature: ______________________

Date: ______________________

Witness Statement

Witness Name: ______________________

Signature: ______________________

Date: ______________________