Advanced Care Planning Questionnaire

Dear [Recipient's Name],

As part of our commitment to ensuring that your healthcare preferences are honored, we would like to gather information regarding your wishes for future medical care. Please take a moment to complete this advanced care planning questionnaire.

Personal Information

Name: [Your Name]

Date of Birth: [Your Date of Birth]

Emergency Contact: [Contact Name] - [Phone Number]

Health Preferences

1. In the event of a life-threatening illness, do you wish to pursue aggressive treatments?

[ ] Yes [ ] No

2. Do you have preferences about resuscitation (CPR)?

[ ] Yes [ ] No

If yes, please specify: ______________________

Values and Goals

3. What are your most important goals for your care?

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4. Are there any specific treatments you wish to avoid?

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Additional Notes

Feel free to share any additional information that may help guide your care:

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Thank you for taking the time to express your preferences. Your responses will be kept confidential and used to guide your future care.

Sincerely,
[Your Healthcare Provider's Name]
[Contact Information]