



ADVANCE DIRECTIVE NOTIFICATION FORM

You have the right to give instructions about your health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form you may complete or change all or any part of it. You are free to use a different form.

Part 1: Power of Attorney

I have talked to my family about the care I want. If I am unable to speak for myself, I would like to have the following contacted:

Initial Agent _____ Number _____

If I revoke the authority of my agent or my agent is not willing, able or reasonably available to make health care decisions for me, I designate my first alternate agent:

Alternate #1 Agent _____ Number _____

If I revoke the authority of my agent and first alternate agent or if they are not willing, able or reasonably available to make health care decisions for me, I designate my second alternate agent:

Alternate #2 Agent _____ Number _____

Part 2: Instruction for Health Care

End of Life decisions:

- Choice not to prolong life** if (1) I have an incurable and irreversible condition that will result in my death within a relatively short (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness or (3) the likely risks and burdens of treatment would outweigh the expected benefits

- Choice to prolong life** as long as possible within limits of generally accepted medical treatment standards.

Other wishes: different or more specific instructions other than those marked above such as: what you consider reasonable quality of life, treatments you would consider burdensome or unacceptable

Part 3: Donation of Organs at death

- I give any needed organs, tissues or parts
- I give the following organs, tissues or parts: _____
- I do not wish to donate any organs, tissues or parts

My gift of my organs, tissues or parts are for all of the following (uncheck any of the following you do not wish to donate for):

Transplant	Therapy	Research	Education
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Part 4: Primary Physician

I designate the following physician as my primary treating physician:

Mike Romeo MD	Carrie Janiski, DO	Michael Lawrence, OEH-ANP	Dr. Jenny Wong, DO
Dr. Daniel, DO	Briana Luna, PA-C	Other:	

I understand that is not the responsibility of Romeo Medical Clinic to notify hospitals or other providers of my advance directive or living will. I understand that the information is however available to hospitals or other providers upon requests.

Printed Name of Patient

Signature of Patient

Date