Division of Health Licensure and Regulation, Board of Health Care Facilities, Licensure

PROVIDER IDENTIFICATION OF SURROGATE

I, _____ have identified _____
Print Name of Designated Physician — Print Name of Surrogate

as surrogate decision maker for _____, based on the criteria below.
Print Name of Patient

Surrogate Identity and Contact Information:

Relationship to patient: _____
Address: _____
_____
_____

Home Phone:(_____) _____
Work Phone:(_____) _____
Cell Phone:(____) _____
Other:(_____) _____

Criteria considered in identification of surrogate (mark all that apply):

- ☐ exhibits special care and concern for patient
- ☐ familiar with patient's personal values/wishes
- ☐ reasonably available
- ☐ willing to serve
- ☐ able to act in accordance with patient's known wishes/best interests
- ☐ regular contact with patient prior to/during illness
- ☐ able to visit patient during illness
- ☐ available for face-to-face contact with providers
- ☐ able to participate in the decision-making process

_____ _____
Physician's Signature — Date/Time

Any individuals in disagreement? ☐ Yes ☐ No If yes, please explain: _____
_____
_____

Acceptance by Surrogate: I agree to serve as surrogate decision maker for the patient named above and am able and willing to make medical decisions on the patient's behalf.

_____ _____
Surrogate's Signature — Date/Time

If no surrogate can be identified, the designated physician (_____) may make health care decisions for the patient after obtaining one of the following signatures:

I certify that the designated physician has consulted with and obtained the recommendations of the facility's ethics mechanism:

_____
Print Name of Facility Ethics Representative

_____
Signature of Facility Ethics Representative

_____
Date/Time

I am a physician not directly involved in the patient's care; I do not serve in a capacity of decision-making, influence, or responsibility over the designated physician; I am not under the designated physician's decision-making, influence, or responsibility; and I concur in the care plan for this patient.

_____
Print Name of Second Physician

_____
Signature of Second Physician

_____
Date/Time