Health Care Surrogate Worksheet

PATIENT'S NAME:_____ DOB:

Directions: This form is used to specify the type of surrogate who is allowed to make health care decisions for the above patient when s/he is unable to do so per ARS 36-3231. The person responsible for locating a surrogate decision-maker shall contact the following individual(s) in the indicated order of priority below who are available and willing to serve as a surrogate. Documentation of contacts/results may be noted on this form and/or in the patient's chart.

SELECT ONE:

APPOINTED SURROGATE(S): A person authorized to make health care decisions on behalf of the patient.

__ Court appointed guardian appointed for the express purpose of making health care treatment decisions (place copy in medical record)

__ Agent under health care power of attorney (place copy in medical record)

IF NEITHER IS AVAILABLE, make reasonable efforts to contact the statutory surrogate(s) and verify that the person(s) is unwilling or unable to serve as surrogate decision maker before moving to the next in priority:

__ 1. The patient's spouse (unless the patient and spouse are legally separated) _____

__ 2. An adult child of the patient (if the patient has more than one adult child, the health provider shall seek the consent of a majority of adult children who are reasonably available for consultation) - list all children serving as surrogates below_____

__ 3. A parent of the patient _____

__ 4. If the patient is unmarried, the patient's domestic partner (if no other person has assumed any financial responsibility for the patient) _____

__ 5. A brother or sister of the patient _____

6. A close friend of the patient (an adult who has exhibited special care and concern for the patient, who is familiar with the patient's health care views and desires and who is willing and able to become involved in the patient's health care and to act in the patient's best interest) _____

IF NONE OF THE ABOVE CAN BE LOCATED:

__ Attending physician

a. After the physician consults with and obtains the recommendations of an institutional ethics committee

OR IF THIS NOT POSSIBLE

b. After consulting with a second physician who concurs with the physician's decision

NOTES:_____

IDENTIFIED SURROGATE(S) - please include name, relationship to the patient, address, and phone number(s), for each identified surrogate: _____

This health care surrogate worksheet is <u>not</u> an advance/health care directive. The above named surrogate(s) was identified by the health provider/facility on the following date listed below.

PERSON COMPLETING FORM: _____DATE:_____
TITLE:_____ HEALTH PROVIDER/FACILITY: ____