



Please send completed questionnaire to:  
**Aaron, Riechert, Carpol & Riffle, APC**  
 333 Twin Dolphin Drive, Suite 350  
 Redwood City, CA 94065  
 Main Number: 650.368.4662  
 General Fax: 650.367.8531

## HEALTHCARE DIRECTIVE QUESTIONNAIRE

Please complete this form and return to the address listed above. For optimum accuracy, please type or print clearly. If necessary please use additional sheets of paper to answer the questions.

GENERAL CLIENT INFORMATION				
NAME (LAST)	FIRST	MI		
STREET ADDRESS	CITY	STATE	ZIP CODE	
HOME TELEPHONE	WORK/ALTERNATE TELEPHONE		EMAIL	
<b>1</b>	<b>HAVE YOU EVER EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE OR A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE SUBMIT COPIES.			
<b>2</b>	<b>WHO WOULD YOU LIKE TO APPOINT TO MAKE YOUR MEDICAL DECISIONS FOR YOU?</b> PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER. (CELL PHONE, OR E-MAIL)			
NAME (LAST)	FIRST	STATE		MI
STREET ADDRESS	CITY	STATE	ZIP CODE	
HOME TELEPHONE	WORK/ALTERNATE TELEPHONE		EMAIL	
<b>3</b>	<b>WOULD YOU LIKE TO APPOINT AN ALTERNATE AGENT IN THE EVENT THIS AGENT IS NOT WILLING, ABLE, OR REASONABLY AVAILABLE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER.			
NAME (LAST)	FIRST	STATE		MI
STREET ADDRESS	CITY	STATE	ZIP	
HOME TELEPHONE	WORK/ALTERNATE TELEPHONE		EMAIL	
<b>4</b>	<b>WOULD YOU LIKE THIS AUTHORITY TO TAKE EFFECT ONLY ON YOUR INCAPACITY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>5</b>	<b>DO YOU WISH TO AUTHORIZE YOUR PHYSICIAN TO RELEASE PROTECTED MEDICAL INFORMATION ABOUT YOUR CAPACITY TO FAMILY MEMBERS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST BELOW.			

PLEASE SELECT THE PERSON (S) WITH WHOM YOU AUTHORIZE YOUR PHYSICIAN TO RELEASE THE ABOVE INFORMATION TO (SELECT ALL THAT APPLY)

- YOUR AGENT AS LISTED IN THIS ADVANCE HEALTH CARE DIRECTIVE
- YOUR SUCCESSOR TRUSTEE
- YOUR ATTORNEY

WOULD YOU LIKE THIS AUTHORIZATION TO TAKE EFFECT IMMEDIATELY, OR ONLY UPON A DETERMINATION OF YOUR INCAPACITY?

**6** END OF LIFE DECISIONS: WOULD YOU LIKE HEROIC MEASURES TO BE PERFORMED TO SAVE YOUR LIFE IF THE EXTENSION OF YOUR LIFE RESULTS IN A MERE BIOLOGICAL EXISTANCE, WITH NO HOPE OF MEANINGFUL RECOVERY?  YES  NO

**7** PAIN RELIEF: WOULD YOU LIKE PAIN MEDICATIONS ADMINISTERED EVEN IF IT MIGHT HASTEN YOUR DEATH?  YES  NO

**8** ORGAN DONATIONS: WOULD YOU LIKE ANY OR ALL OF YOUR ORGANS TO BE DONATED IN THE EVENT OF YOUR DEATH?  
 YES  NO IF YES, PLEASE LIST:

DONATED ORGANS TO BE USED FOR (PLEASE SELECT ALL THAT APPLY):

- TRANSPLANT
- RESEARCH
- EDUCATIONAL PURPOSES

**9** DISPOSITION OF REMAINS: DO YOU HAVE ANY SPECIFIC DESIRES REGARDING THE DISPOSITION OF YOUR REMAINS? (I.E. BURIAL V. CREMATION AND/OR SPECIFIC FUNERAL INSTRUCTIONS)  YES  NO IF YES, PLEASE LIST:

**10** PLEASE PROVIDE YOUR PRIMARY CARE PHYSICIAN'S INFORMATION

NAME (LAST)	FIRST	MI
STREET ADDRESS	CITY	STATE ZIP CODE
HOME TELEPHONE	WORK /ALTERNATE PHONE	EMAIL

**11** WOULD YOU LIKE TO INCLUDE AN INSTRUCTION REQUESTING THAT YOU BE KEPT IN YOUR HOME AS LONG AS REASONABLY POSSIBLE?  YES  NO