Please send completed questionnaire to:
Aaron, Riechert, Carpol & Riffle, APC
333 Twin Dolphin Drive, Ste. 350
Redwood City, CA 94065
General Fax: 650.367.8531
General Email: info@arcr.com

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

LAST NAME	FIRST NAME		MI
STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE#	CELL PHONE#	BUSINESS PHONE#	
EMAIL ADDRESS(ES)			

1	**HAVE YOU EVER EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE OR A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?** ◯ **YES** ◯ **NO** IF YES, PLEASE SUBMIT COPIES WITH THIS QUESTIONNAIRE EITHER BY MAIL OR EMAIL
2	**WHO WOULD YOU LIKE TO APPOINT AS YOUR AGENT TO MAKE YOUR MEDICAL DECISIONS FOR YOU?** PLEASE PROVIDE NAME AND CONTACT INFORMATION BELOW

LAST NAME	FIRST NAME		MI
STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE#	CELL PHONE#	BUSINESS PHONE#	
EMAIL ADDRESS(ES)			

3	**WOULD YOU LIKE TO APPOINT AN ALTERNATE AGENT IN THE EVENT THIS AGENT IS NOT WILLING, ABLE, OR REASONABLY AVAILABLE?** ◯ **YES** ◯ **NO** IF YES, PLEASE PROVIDE NAME AND CONTACT INFORMATION BELOW

LAST NAME	FIRST NAME		MI
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE#	CELL PHONE#	BUSINESS PHONE#	
EMAIL ADDRESS(ES)			

4	**WOULD YOU LIKE THIS AUTHORITY TO TAKE EFFECT ONLY ON YOUR INCAPACITY?** ◯ **YES** ◯ **NO**

5 **DO YOU WISH TO AUTHORIZE YOUR PHYSICIAN TO RELEASE PROTECTED MEDICAL INFORMATION ABOUT YOUR CAPACITY TO FAMILY MEMBERS?** ◯ **YES** ◯ **NO** IF YES, PLEASE SPECIFY

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?
◯ **IMMEDIATELY** ◯ **ONLY UPON 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 EXISTENCE, 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: DO YOU HAVE AN ORGAN DONATION ON FILE WITH THE DMV OR ANY OTHER ORGANIZATION?**
◯ **YES** ◯ **NO** IF YES, PLEASE SPECIFY

IF NO, WOULD YOU LIKE ANY OR ALL OF YOUR ORGANS TO BE DONATED IN THE EVENT OF YOUR DEATH?
◯ **YES** ◯ **NO** IF YES, PLEASE SPECIFY

IF YES, PLEASE INDICATE WHAT YOU APPROVE YOUR 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** ◯ **LEAVE TO DISCRETION OF NOMINATED AGENT, IN ORDER OF PRIORITY**. IF YES, PLEASE SPECIFY

DO YOU WANT YOUR AGENT TO HAVE THE POWER TO AUTHORIZE AN AUTOPSY IF NECESSARY? ◯ **YES** ◯ **NO**

DO YOU WANT TO INCLUDE AND SPECIFIC INSTRUCTIONS REGARDING THE NATURE OF YOUR MEMORIAL SERVICES? (I.E. OUTDOORS, RELIGIOUS OR SPIRITUAL BELIEFS AND/OR CUSTOMS, RESTRICTIONS, ETC.)
◯ **YES** ◯ **NO** IF YES, PLEASE SPECIFY

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

LAST NAME	FIRST NAMES		MI
STREET ADDRESS	CITY	**S**TATE	ZIP CODE

BUSINESS PHONE#	CELL 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**
12	**HOW WOULD YOU DESCRIBE YOUR CURRENT HEALTH?** ◯ **EXCELLENT** ◯ **GOOD** ◯ **FAIR** ◉ **POOR** IF YOU WISH TO ELABORATE ON THIS ANSWER, PLEASE DO SO BELOW
13	**WOULD YOU LIKE TO INCLUDE INSTRUCTIONS RESTRICTING VISITATION FROM ANY SPECIFIC PERSON (IN THE HOSPITAL, DURING IN-HOME CARE, ETC.)?** ◯ **YES** ◯ **NO** IF YES, PLEASE SPECIFY
14	**DO YOU HAVE ANY RELIGIOUS PREFERENCES OR CUSTOMS THAT SHOULD BE CONSIDERED IN YOUR HEALTH CARE DECISIONS?** ◯ **YES** ◯ **NO** IF YES, PLEASE SPECIFY
15	**DO YOU HAVE ANY ADDITIONAL INSTRUCTIONS YOU WOULD LIKE TO HAVE YOUR AGENT FOLLOW?** ◯ **YES** ◯ **NO** IF YES, PLEASE SPECIFY