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

HEALTH CARE 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)	PREFERRED PRONOUNS		

1 **HAVE YOU EVER EXECUTE 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)	PREFERRED PRONOUNS		

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.
(*IF YOU WISH TO NAME ALTERNATE AGENTS, PLEASE DO SO ON THE LAST PAGE OF THIS QUESTIONNAIRE.* **)**

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

5	**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**
6	**PAIN RELIF: WOULD YOU LIKE PAIN MEDICATIONS ADMINISTERED EVEN IF IT MIGHT HASTEN YOUR DEATH?** ☐ **YES** ☐ **NO**
7	**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

8	**DISPOSITION OF REMAINS: DO YOU HAVE ANY SPECIFIC DESIRES REGARDING THE DISPOSITION OF YOUR REMAINS (I.E. BURIAL V. CREMATION AND/OR SPECIFC FUNERAL INSTRUCTIONS)?** ☐ **YES** ☐ **NO** ☐ **LEAVE TO DISCRETION OF NOMINATED AGENT, IN ORDER OF PRIORITY** IF YES, PLEASE SPECIFY:

DO YOU HAVE A PRE-PAID OR PRE-ARRANGED FUNERAL PLAN (I.E. A PRE-PAID BURIAL PLAN)?
☐ **YES** ☐ **NO** 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 ANY SPECIFY INSTRUCTIONS REGARDING THE NATURE OF YOUR MEMORIAL SERVICES (I.E. OUTDOORS, RELIGIOUS OR SPIRITUAL BELIEFS AND CUSTOMS, PREFERRED NAMES, GENDER EXPRESSION, RESTRICTIONS, ETC.)?
☐ **YES** ☐ **NO** IF YES, PLEASE SPECIFY

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

LAST NAME	FIRST NAME		MI
STREET ADDRESS	CITY	STATE	ZIP CODE

BUSINESS PHONE #	CELL PHONE #	EMAIL ADDRESS

10	**WOULD YOU LIKE TO INCLUDE AN INSTRUCTION REQUESTING THAT YOU BE KEPT IN YOUR HOME AS LONG AS REASONABLY POSSIBLE? ☐ YES ☐ NO**
11	**HOW WOULD YOU DESCRIBE YOUR CURRENT HEALTH? (**IF YOU WISH TO ELABORATE, PLEASE DO SO BELOW.**)** ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

12	**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
13	**DO YOU HAVE ANY RELIGIOUS PREFERENCES OR CUSTOMS THAT SHOULD BE CONSIDERED IN YOUR HEALTH CARE DECISIONS?** ☐ **YES** ☐ **NO** IF YES, PLEASE SPECIFY
14	**DO YOU HAVE ANY ADDITIONAL INSTRUCTIONS YOU WOULD LIKE TO HAVE YOUR AGENT FOLLOW?** ☐ **YES** ☐ **NO** IF YES, PLEASE SPECIFY
15	**ADDITIONAL NOTES:**