Please send completed questionnaire to:
**Aaron, Riechert, Carpol & Riffle, APC**
900 Veterans Blvd., Suite 600
Redwood City, CA 94063
**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 |
|---|---|---|
| | | |

**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.

**2** **WHO WOULD YOU LIKE TO APPOINT TO MAKE YOUR MEDICAL DECISIONS FOR YOU?**
PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER. (PAGER, CELL PHONE, OR E-MAIL)

| NAME (LAST) | FIRST | MI |
|---|---|---|
| | | |

| STREET ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

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| | | |

**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, ADDRESS, AND TELEPHONE NUMBER.

| NAME (LAST) | FIRST | MI |
|---|---|---|
| | | |

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|---|---|---|---|
| | | | |

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|---|---|---|
| | | |

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

**5** **DO YOU WISH TO AUTHORIZE YOUR PHYSICAN TO RELEASE PROTECTED MEDICAL INFORMATION ABOUT YOUR CAPACITY TO FAMILY MEMBERS? ☐ YES ☐ 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 BIOLOCIAL 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 PHYSICAN'S INFORMATION**

| NAME (LAST) | FIRST | MI |
|---|---|---|
| | | |

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| | | | |

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|---|---|---|
| | | |

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