West Coast Family Practice
For your Health
www.wctampa.com

Gail Sadler, APRN-BC Theata J. Merritt, APRN-BC

11018 N. Dale Mabry Hwy, Ste. 401, Tampa, FL 33618 PH: 813-961-9393 FX: 813-960-9020

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedures (LIVING WILL) : *(please check one)*

☐ I have made such declaration ☐ I have NOT made such a declaration

Health Care Surrogate :

☐ I have designated a Health Care Surrogate ☐ I have NOT designated a Health Care Surrogate

Durable Power of Attorney :

☐ I have appointed a Durable Power of Attorney for Health Care decisions

☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

Print Patient Full Name:	Social Security #: - -
Patient Signature:	Date:
Relationship of Patient Representative if applicable:	

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

Signature of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	Date:

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Legal Representative:	**Date:**

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LIVING WILL

Declaration made this _____ day of _____, 20_____ in the State of Florida, _____ COUNTY.

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and,

_____ *(Initial)* I have a terminal condition,

_____ *(Initial)* I have an end stage condition,

_____ *(Initial)* I am in a persistent vegetative state,

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I DO _____, I DO NOT _____, desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express or informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to delegate, as my health surrogate to carry out the provisions of this declaration:

Name _____

Street Address: _____

City: _____ State: _____ Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____

_____

_____

Patient Signature:	**Date:**

Witness Signature:	Address:	Date:
Witness Signature:	Address:	Date:

At least one witness must sign, must not be husband or wife or blood relative of the principal.