HEALTHCARE CONTACTS AND DIRECTIVES

Name_______________________________________ Date ____________________

Primary care physician

Name ______________________________ Phone _________________

Address ____

Notes ____

Hospital

Name ______________________________ Phone __________________

Address ____

Notes ____

People to contact in case of medical emergency:

Name _________________________________ Relationship __________________

Phone number(s) ____

Name _________________________________ Relationship __________________

Phone number(s) ____

Name _________________________________ Relationship __________________

Phone number(s) ____

Name _________________________________ Relationship __________________

Phone number(s) ____

Health care directives (the AHCD suffices for both the POA and living will)

I have a (check those that apply):

Advance Health Care Directive ____ Where located___________________

Power-of-Attorney for health care ____ Where located___________________

Living will ___ Where located___________________

Do Not Resuscitate (DNR) and Vial of Life

I have a DNR form ____ Where located _____________________________

I have a Vial of Life ____ Where located _____________________________