Advance Care Planning Participant Information Sheet – CONFIDENTIAL

Name: _____

Address: _____ **Zip Code:** _____

Phone #: _____ **Email:** _____

Gender: ☐ M ☐ F **Age Range:** ☐ 19-30 ☐ 31-50 ☐ 51-65 ☐ 66-80 ☐ 81-90 ☐ 91+

My goal for attending Advance Care Planning meeting today: Check all that apply.

☐ Find out what Advance Care Planning is	☐ Find out what a Medical Power of Attorney is	☐ Talk about my fears and concerns	☐ Find out what specific paperwork I want to fill out	☐ Review my completed paperwork	☐ Find out what else I need to do and who to tell

Advance Care Plan Paperwork I have already signed: Check all that apply.

☐ Medical Power of Attorney	☐ Durable Power of Attorney	☐ Living Will / Directive to Doctor & Family	☐ Out of Hospital Do-not-Resuscitate (DNR)	☐ None

I would like to talk to someone privately about Advance Care Planning:
Name: _____
Phone Number or Email: _____

For FCN Only:

Status of Advance Care Planning

☐ Advance Care Planning Discussion Initiated	☐ Agent has been selected	☐ Agent has accepted	☐ Discussion in progress	☐ Advance Care Plan completed and signed	☐ No action at this time

Signed copy on file at congregation? ☐ Yes ☐ No ☐ Other location_____

Notes:

Additional follow up:

Expressed preferences/wishes converted to an Advance Directive or Medical Order: ☐ Yes ☐No