SLEZAK COLORECTAL SURGICAL CLINIC, PL

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Today's Date: _____

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

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

{ } I have made such a declaration
{ } I have NOT may 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.

_____ _____
Patient's or Representative's Signature Date Signed

YEARLY RECONFIRMATION: By signing below I acknowledge that the above information remains accurate.

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Patient's or Representative's Signature Date Signed

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