COMPREHENSIVE CANCER CENTER

# New Patient Information

You have an appointment scheduled at the UNM Comprehensive Cancer Center. Please review the enclosed information, instructions and forms needed for your appointment. For more information, visit our web site at cancer.unm.edu.

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**Your appointment with Dr.** **is scheduled on:**

**Please arrive at the Center to register at:**

**Your appointment time is scheduled for:**

1. **If you need to cancel or reschedule an appointment,** please call the UNM Cancer Center at 505-272-4946 at least 24 hours before your scheduled appointment. If you miss your appointment, we will attempt to contact you.
2. **Arrive 30 minutes before your appointment.** Please arrive 30 minutes before your scheduled appointment so you will have enough time to park and register.
3. **Go to the 1st floor to Check-in and register.**

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We will do everything we can to make sure you are seen at your scheduled appointment time. However, there may be times when you have to wait longer than expected due to unforeseen emergencies or situations that require the doctors' attention.

Interpreter Services are available. Please call 505-272-4946 to request.

## Insurance and Billing Information

Most insurance coverage is accepted at the UNM Cancer Center. If you do not have insurance, we will schedule an appointment for you with a financial counselor for assistance and/or payment plan options. If you will be paying cash, please be prepared to pay a $50.00 co-pay at time of service. You will be billed for any additional charges incurred during your visit including but not limited to physician fees, lab work, X-rays, medications or procedures.

You will receive separate bills for your hospital and physician services. You will receive bills from UNM Hospitals with charges for use of the facility, lab work, diagnostic testing and procedures. Your physician fees, such as visits with your provider and charges involving review and reading of your diagnostic tests, will be billed out by the University of New Mexico Medical Group. We know that keeping track of your medical bills during a time of an illness is an added challenge, so please reach out for assistance if you have questions at 505-925-6617.

COMPREHENSIVE CANCER CENTER

# INITIAL PATIENT ASSESSMENT

Please complete this form and bring to your first visit.

Print Name_____ Date_____

Medical Record Number_____

**1. What is your primary language?**_____

Interpreter required? No ☐ Yes ☐ Name of interpreter_____

**2. Reason for today's visit** (clinical use only)_____

**3. Past History**

**Past/chronic illnesses**
please check those that apply or list below

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Arthritis
- ☐ Other Cancer(specify)

_____

_____

**Other information**

Immunizations_____

Dietary status_____

**4. Allergies**

Frequent infections No ☐ Yes ☐

Seasonal rhinitis No ☐ Yes ☐

Allergy medications No ☐ Yes ☐

If yes, please list your allergy medications:

_____

_____

**Do you have any allergies to:**

Medicines No ☐ Yes ☐

Foods No ☐ Yes ☐

Environmental-Seasonal No ☐ Yes ☐

If yes, please list and describe your allergic reaction(s):

_____

**5. Past Surgical History**

Have you ever been in the hospital or had surgery?

If yes, please describe type of surgery and what year:

_____

_____

**6. Social History/Historia Social**

Do you live alone? No ☐ Yes ☐

If no, list who lives with you:

_____

Do you or have you ever smoked? No ☐ Yes ☐

If yes, how many packs per day?_____

For how many years?_____

If you have quit smoking, for how many years? _____

Do you, or have you used chewing tobacco? No ☐ Yes ☐

Do you, or have you ever used recreational drugs? No ☐ Yes ☐

Do you or have you ever used alcohol? No ☐ Yes ☐

Are you sexually active? No ☐ Yes ☐

Any changes in sexual function? No ☐ Yes ☐

**Marital status** (Please check one)

☐ Single ☐ Married ☐ Partner
☐ Divorced ☐ Widowed

**Ethnicity** (Choose one of the following)

- ☐ I choose NOT to report ethnicity or race
- ☐ African American
- ☐ Asian
- ☐ Latino-Hispanic
- ☐ More than one race
- ☐ Native Hawaiian - Pacific Islands
- ☐ Native American
- ☐ Unknown - not reported
- ☐ White

**7. Family History/Historia Familiar**

Family history of cancer No ☐ Yes ☐

If yes, please list who (blood related), what type of cancer and at what age they were diagnosed:

_____

PATIENT LABEL

**Patient's signature**_____ **Date**_____

**Provider's signature** _____ **Date**_____

PLEASE COMPLETE OTHER SIDE

**8. REVIEW OF SYMPTOMS** (Please check No or Yes)

**Constitutional**

Fever No ☐ Yes ☐
Weight loss in past 6 months No ☐ Yes ☐
Night sweats No ☐ Yes ☐
Fatigue - change in energy level No ☐ Yes ☐
If yes, describe:_____

_____

Sleep problems No ☐ Yes ☐

**Gastrointestinal**

Vomit No ☐ Yes ☐
Heartburn No ☐ Yes ☐
Trouble with swallowing No ☐ Yes ☐
Constipation No ☐ Yes ☐
Diarrhea No ☐ Yes ☐
Nausea No ☐ Yes ☐
Black or bloody stool No ☐ Yes ☐

**Neurologic**

Pins and needles sensation No ☐ Yes ☐
Weakness No ☐ Yes ☐
Numbness No ☐ Yes ☐

**Endocrine**

Heat or cold intolerance No ☐ Yes ☐
Increased amount of urine No ☐ Yes ☐
Excessive sweating No ☐ Yes ☐
Increased fluid intake No ☐ Yes ☐

**Hematologic-Lymphatic**

Excess bleeding after cut No ☐ Yes ☐
Enlargement or tenderness of lymph glands No ☐ Yes ☐

**Eyes**

Any changes in vision No ☐ Yes ☐
Eye pain No ☐ Yes ☐

**Ears-Nose-Throat-Head-Neck**

Ear pain or ringing No ☐ Yes ☐
Nasal congestion No ☐ Yes ☐
Dry mouth No ☐ Yes ☐
Hoarseness No ☐ Yes ☐
Sore throat No ☐ Yes ☐

**Respiratory**

Cough No ☐ Yes ☐
Difficulty breathing No ☐ Yes ☐
Wheezing No ☐ Yes ☐

**Psychological**

Depression No ☐ Yes ☐
Anxiety No ☐ Yes ☐

**Genitourinary**

Frequent need to urinate
Necesidad de orinar frecuentemente No ☐ Yes ☐
Painful urination No ☐ Yes ☐
Bloody or tea-colored urine No ☐ Yes ☐
Get up at night to urinate No ☐ Yes ☐
Leakage of urine No ☐ Yes ☐
Weak urinary stream No ☐ Yes ☐
Problems with erections No ☐ Yes ☐
Heavy menses No ☐ Yes ☐

**Musculoskeletal**

Muscle Problems No ☐ Yes ☐
Joint Problems No ☐ Yes ☐
Bone pain No ☐ Yes ☐

**Cardiovascular**

Chest pain No ☐ Yes ☐
Irregular heartbeats No ☐ Yes ☐
Pain in the back of the legs with walking No ☐ Yes ☐

**Skin**

Rash No ☐ Yes ☐
Hives No ☐ Yes ☐
Change in skin color No ☐ Yes ☐
Lump or thickening No ☐ Yes ☐
Changing Moles No ☐ Yes ☐

**For Women**

Are you pregnant? No ☐ Yes ☐
Are you or your partner using any
birth control at this time? No ☐ Yes ☐
Date of last menstrual period _____
Length of period_____
Age at first menses_____
Number of past pregnancies_____
Number of live births_____
Age at first birth_____
Number of living children_____
If you have nursed children, how many months?_____
Have you ever taken:
Hormone pills No ☐ Yes ☐
Birth control pills No ☐ Yes ☐
Are you planning to have children in the future? No ☐ Yes ☐
Have you ever had a breast biopsy? No ☐ Yes ☐
Results:_____
When did you last have a pap smear?_____

PATIENT LABEL

COMPREHENSIVE CANCER CENTER

# Medication List

Patient Name:_____Date:_____

Date of Birth:_____Medical Record #:_____

Please list any allergies you might have: _____

_____

_____

Please include below: ALL over the counter medications (for example, Tylenol) and ALL Herbal medications.

| Medication | Dose or strength | How often do you take it? | Reason or why do you take it? |
|---|---|---|---|
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DO NOT WRITE BELOW THIS LINE – STAFF USE ONLY

Completed by_____Title_____Date_____

COMPREHENSIVE CANCER CENTER

# Frequently Asked Questions

## 1 Where do I park when I have to visit the UNM Comprehensive Cancer Center?

You have options for parking during your visit:

- East side of the building where you enter the building on the first floor. You may have your vehicle valet parked for free.
- West side of the building. Patient Parking is designated in rows 4 through 9 and the row that runs North/South on the Westside. Please be sure the space you park in is labeled "Patient Parking Only". You will enter the building on the ground floor near the Radiation Oncology Check-in Desk. (Please see attached Patient Parking map)
- Oversized Vehicle Lot at the St. Paul Lutheran Church. Patients traveling in an oversized vehicle must park in this designated lot. Please contact UNM Cancer Center at 505-272-4946 or 1-800-432-6808 prior to your clinic appointment to make arrangements for shuttle pick up at the Oversized Vehicle Lot. Oversized vehicles are: Recreation Vehicles (RV's), large bus type vehicles, vehicles with attached trailers, or any other vehicle that cannot fit in a single parking space without obstructing the right away or crowding an adjacent parking space. (Please see attached map Location D).
- Handicap parking spaces available in rows 7 through 9. If there are not any handicap spaces available, you may park in any of the other green striped patient parking spaces; or you may go to the East entrance and have your car valet parked for free.

## 2 Where do I Register/Check-in for my appointment?

If you have a Radiation Oncology appointment you may register/check-in for that appointment on the ground floor Radiation Oncology Check-in Desk. If you have multiple appointments and your first appointment of the day is for Radiation Oncology, you may check-in for ALL appointments at the ground floor Radiation Oncology Check-in Desk. If you do not have a Radiation Oncology appointment, or the Radiation Oncology appointment is not your first appointment of the day, you should check in at the Reception Check-in Desk on the first floor.

## 3 Do I need to go to the Reception-Check-in Desk if I need labs from TriCore or X-rays?

No, you may go directly to the appropriate department to get these services. If you have a UNM Cancer Center appointment as well, then you can go to the Reception Check-in Desk on the first floor AFTER you have completed these tests.

## 4 Why am I asked for my address, phone number and insurance every time I check in for an appointment?

We want to ensure we have the correct contact information in case a Physician or other provider needs to contact you. Insurance is verified at each visit. Medicare requires us to ask a series of questions every 90 days for any recurring visits.

## 5 What areas are on the different floors?

**Ground Floor**
West Parking Lot Entrance, Radiation Oncology, Medical Records

**First Floor**
East Parking Lot Entrance, Reception Check-in, Tricore Laboratories, UNMH Radiology, Hematology/Oncology Clinic

**Second Floor**
Women's Clinic

**Third Floor**
Hematology/Oncology Clinic

**Fourth Floor**
Infusion Suite

## 6 Why am I told there will be an electronic message sent when I call to speak to someone?

When a "live" person is not available to speak with you immediately, our operators will send an electronic message to the appropriate staff to help expedite a return call. This system allows us to track calls to ensure that we return them in a reasonable time.

## 7 Why am I required to wear an orange wristband?

We want to ensure we are treating the correct person. Throughout your visit you will frequently be asked for your name and date of birth. We compare the information you give us to the information on the wrist band to make sure we have the right person every time.

## 8 Am I able to bring my family and friends to my visits?

Yes, you may bring your family and friends. All visitors who come with our patients will be given a yellow wristband.

## 9 May I bring children to the UNM Cancer Center?

Yes, except for the Infusion suite. Children 14 years and younger are not permitted in the Infusion Suite. Please do not leave your children unattended while at the UNM Cancer Center.

## 10 Where can I find food in the building?

The El Oso Café located on the first floor and is open from 7 am to 4 pm. The café entrance is just west of the information desk. Visit www.cinnamoncafeabq.com to view the menu and call 505-925-0068 to order for pick-up. Coffee is available on the first and third floor lobbies. You are always welcome to bring food or snacks if you are scheduled to be at the Cancer Center for an extended period of time.

## 11 Am I able to use my cell phone while at the Cancer Center?

You may bring and use your cell phone in the building, but we ask that you be courteous to others and keep the volume low.

## 12 Why am I not able to use my e-cigarette inside the building?

The University of New Mexico has a non-smoking campus. The UNM Cancer Center does not allow smoking of any kind in the building or in the parking lot.

## 13 Does the Cancer Center permit animals in the building?

- Only service animals are permitted in the clinic.
    - According to the ADA, emotional support animals are not considered service animals
- Service animals must be on a leash or harness at all times.
- There are areas where animals may not be allowed, such as procedure, operating and radiation treatment rooms or where isolation precautions are in place.
    - If your treatment requires you to be in one of these areas, please arrange in advance for someone to care for your animal.
- The UNM Cancer Center will not accept financial responsibility for any infections or health concerns that the service animal may acquire while on the premises.
- If a service animal is aggressive, too noisy, can't contain bodily secretions, or is believed to be ill or infectious, the animal will need to leave.
    - If the animal needs to leave, the patient will be given an opportunity to have someone come to take the animal.

# DIRECTIONS

**1201 Camino de Salud NE • Albuquerque, NM 87102**

Call 505-272-4946 with questions

COMPREHENSIVE CANCER CENTER

## Step 1 — Getting to Our Center

### From I-40 Westbound:

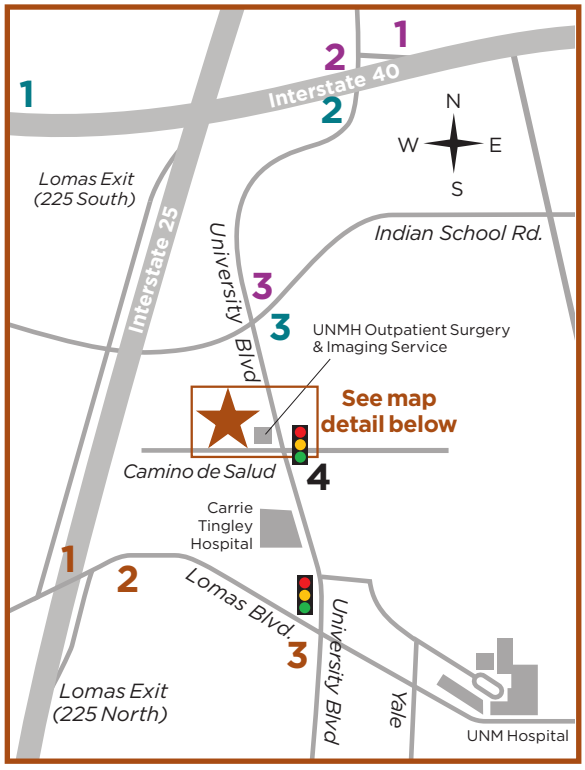
1 Exit I-40 at University (Exit 159D)
2 Turn south (left) on University Blvd
3 Pass Indian School to Camino de Salud

### From I-40 Eastbound:

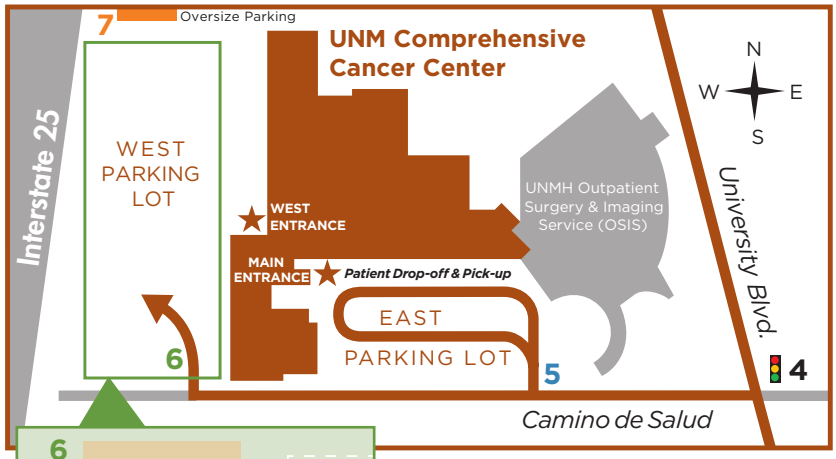
1 Exit I-40 at University (Exit 159A)
2 Turn south (right) on University Blvd
3 Pass Indian School to Camino de Salud

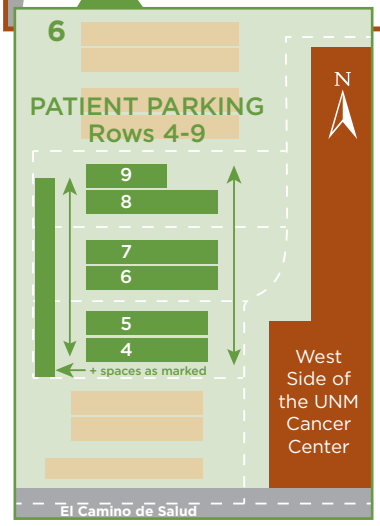
### From I-25 North or Southbound:

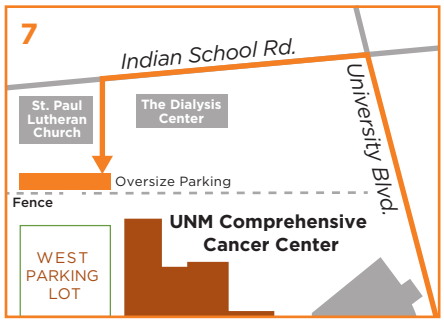
1 Exit I-25 at Lomas Blvd (Exit 225).
2 Go east on Lomas toward the Sandia Mountains until you reach University Blvd (first light).
3 Turn north (left) on University Blvd and follow it to Camino de Salud (first light).




## Step 2 — Drop-off and Parking




**4 Turn west on Camino de Salud** the UNMH Outpatient Surgery and Imaging Service is on the northwest corner. The UNM Comprehensive Cancer Center is the tall building to the west of it.

**5 Patient drop-off and pick-up** is on the east side of the UNM Cancer Center main entrance. Take the first right into the east lot and drive up to the entrance. Free valet parking.

**6 Patient and visitor parking** is available in the west lot only. Continue down the hill and take the next right into the west lot. Enter through the Radiation & Oncology Entrance. Park in rows 4-9 or in the back of the lot.

**7 Oversize parking** is available for RVs or vehicles that can't fit in a single space. Parking is at the St. Paul Lutheran Church. Call us at 505-272-4946 or 1-800-432-6806 before your appointment to arrange for shuttle pick up at the Oversized Vehicle Lot.

**Handicapped parking** is available in both the east and west lots.

# AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: Medical Record #:

1. I hereby authorize the UNM Health Sciences Center to disclose information from my health record at:

[ ] University Hospital
[ ] Children's Psychiatric Hospital
[ ] UNM Medical Group, Inc.
[ ] Other--please specify
[ ] UNM Psychiatric Center
[ ] UNM Cancer Center
[ ] UNM Sandoval Regional Medical Center
[ ] Carrie Tingley Hospital
[ ] Ambulatory Care Center

To: Name: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Provider/Facility Fax : _____

Would you like a CD/DVD of your records? Yes / No Would you like a CD/DVD of your radiology films/images? Yes / No

For the purpose of:

2. Information to be disclosed:

[ ] most recent visit/admission
[ ] history & physical exam
[ ] discharge summary
[ ] physical / occupational therapy records
[ ] operative reports
[ ] outpatient clinic records
[ ] laboratory tests
[ ] radiology reports
[ ] pathology reports
[ ] ER records
[ ] immunization records
[ ] psychological records
[ ] consultation reports
[ ] speech & language records
[ ] all records

Covering the period(s) of healthcare: From (date): _____ To (date): _____

From (date) : _____ To (date):_____

3. I further authorize that this disclosure of health information will include information relating to (initial if applicable):

*(Please initial and check "yes" if labs and/or behavioral health records are requested.)*

[ ] Yes [ ] No Laboratory tests. _____ *initials.*

[ ] Yes [ ] No Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection or other sexually transmitted diseases. _____ *initials.*

[ ] Yes [ ] No Behavioral health services/psychiatric care. _____ *initials.*

[ ] Yes [ ] No Treatment for alcohol and/or drug abuse. _____ *initials.*

[ ] Yes [ ] No Genetic test results and related patient information. _____ *initials.*

4. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months from the date on which it was signed.

5. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this authorization and need not sign this authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed authorization will be provided to me.

Signature, Patient, or legal representative (Relationship to patient) (Date)

Signature of Witness (Date) (Parent, if CPH/PFC&A patient over 14) (Date)

PROHIBITION OF REDISCLOSURE: Federal regulations (42 CFR Part2) and State Laws (NMSA 1978 ## 43-1-19, 32A-6A-24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.

Welcome to the UNM Comprehensive Cancer Center!

In your welcome packet, you will find a form called the “Advanced Directive for Healthcare.” We give this form to every patient who comes to the UNM Cancer Center, whether they are healthy or sick.

The form has two parts. The first part lets you choose a person to make healthcare decisions for you if you cannot make decisions yourself. It is called **Power of Attorney for Healthcare**. The second part lets you tell us what kind of medical care you would want if you were near the end of your life. It is called **Instructions for Healthcare.**

This form protects your rights as a patient. We know it may be hard to fill out this form, but it helps us give you the care you want.

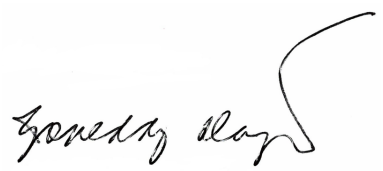
Key things to know about this form:

- You can change it at any time. Just fill out a new one.
  The form is used ONLY if you cannot speak for yourself.
- You can choose to fill out just the first or second part, or all of the form.
- You do not have to fill out this form, but it does help us give you the type of care you want.

If you choose to fill out this form, please bring a copy with you. If you have a different advanced directive that you have already completed and signed, please bring a copy that document with you. We will place the copy of your advanced directive in your file.

If you have questions, please talk to your health care provider. If you need help with these forms, please ask to talk to a social worker when you come to your appointment.

Thank you,



Zoneddy Dayao, MD
Chief Medical Officer
UNM Comprehensive Cancer Center

**24-7A-4. Optional form.**

**OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE**
**Explanation**

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician.

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you use this form, be sure to sign it and date it.

PART 1 of this form is a power of attorney for health care. PART 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
(b) select or discharge health-care providers and institutions;
(b) approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
(c) direct the provision, withholding or withdrawal of artificial nutrition and hydration m and all other forms of health care.

PART 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

* * * * * * * * * * * * * * * * * * * * *

**PART 1**
**POWER OF ATTORNEY FOR HEALTH CARE**

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

_____

(name of individual you choose as agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

_____

(name of individual you choose as first alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

_____

(name of individual you choose as second alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health-care professional determine that I am unable to make my own healthcare decisions. If I initial this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

**PART 2**
**INSTRUCTIONS FOR HEALTH CARE**

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may cross out any wording you do not want.

(6) END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in one of the following three boxes:

[ ] I CHOOSE NOT To Prolong Life
I do not want my life to be prolonged.

[ ] I CHOOSE To Prolong Life
I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

[ ] I CHOOSE To Let My Agent Decide
My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

(7) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong life, I also specify by marking my initials below:

[ ] I DO NOT want artificial nutrition OR
[ ] I DO want artificial nutrition.
[ ] I DO NOT want artificial hydration unless required for my comfort OR
[ ] I DO want artificial hydration.

(8) RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

_____

_____

(9) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

[ ] I CHOOSE to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

[ ] I CHOOSE to make a partial anatomical gift of some of my organs and tissue as specified below, and artificial support may be maintained long enough for organs to be removed.

_____

_____

[ ] I REFUSE to make an anatomical gift of any of my organs or tissue.
[ ] I CHOOSE to let my agent decide.

(10) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed.)

PART 3

PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(phone)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(phone)

* * * * * * * * * * * * * * * * * * * *

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health-care provider and any health-care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising healthcare provider.

(14) SIGNATURES: Sign and date the form here:

_____ _____

(date) (sign your name)

_____ _____

(address) (print your name)

_____ _____

(city) (state) (your social security number)

(Optional) SIGNATURES OF WITNESSES:

First witness Second witness

_____ _____

(print your name) (print your name)

_____ _____

(address) (address)

_____ _____

(city) (state) (city) (state)

_____ _____

(signature of witness) (signature of witness)

_____ _____

(date) (date)