

**I have an advance directive:** Date of document: \_\_\_\_\_

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date of birth: \_\_\_\_\_

**My advance directive is filed at:**

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

©Copyright 2010-2013—All Rights Reserved. Gundersen Lutheran Medical Foundation, Inc.

**I have an advance directive:** Date of document: \_\_\_\_\_

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date of birth: \_\_\_\_\_

**My advance directive is filed at:**

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

©Copyright 2010-2013—All Rights Reserved. Gundersen Lutheran Medical Foundation, Inc.

**I have an advance directive:** Date of document: \_\_\_\_\_

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date of birth: \_\_\_\_\_

**My advance directive is filed at:**

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

©Copyright 2010-2013—All Rights Reserved. Gundersen Lutheran Medical Foundation, Inc.

**I have an advance directive:** Date of document: \_\_\_\_\_

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date of birth: \_\_\_\_\_

**My advance directive is filed at:**

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

©Copyright 2010-2013—All Rights Reserved. Gundersen Lutheran Medical Foundation, Inc.

**I have an advance directive:** Date of document: \_\_\_\_\_

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date of birth: \_\_\_\_\_

**My advance directive is filed at:**

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

©Copyright 2010-2013—All Rights Reserved. Gundersen Lutheran Medical Foundation, Inc.

Honoring Choices®

Honoring Choices®

Honoring Choices®

Honoring Choices®

Honoring Choices®

In Case of Emergency

In Case of Emergency

In Case of Emergency

In Case of Emergency

In Case of Emergency

**My healthcare agent is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My physician is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My healthcare agent is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My physician is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My healthcare agent is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My physician is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My healthcare agent is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My physician is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My healthcare agent is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_

**My physician is:**

My name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_