COVID-19
Advance Care Form

Prepared for: _____

Created by: _____

COVID-19 Advance Care Form

Name: _____ Pronouns: _____

Email: _____

Date: _____

General Screening Information - Draw a check mark next to the appropriate answer for the following prompts:

Vaccination status

- ☐ I have been vaccinated (with all up-to-date boosters as of above date)
  - ☐ Pfizer-BioNTech
  - ☐ Moderna
  - ☐ Johnson & Johnson Janssen
  - ☐ Other: _____
- ☐ I have been vaccinated (missing up-to-date boosters)
- ☐ I have never been vaccinated (by choice)
- ☐ I have never been vaccinated (due to health complications such as disabilities and health disorders)

Guidance to my Trusted Decision Maker(s) and Doctors

In working together to make treatment decisions and plans for my care, please consider my general preferences described here.

Choose ONE option only.

- ☐ I trust my trusted decision maker to do what is best for me.
- ☐ I want to continue living by any means necessary -- including, but not limited to: CPR, feeding tubes, life support machines, and medication -- even if my quality of life seems low to others and I am unable to communicate with people.
- ☐ I would accept intensive treatments.
- ☐ I would accept intensive treatments only if I had a reasonable chance of getting better, but I would refuse long-term support by intensive medications or machines if my quality of life was poor and I was not able to communicate with people.
- ☐ I do not want extraordinary medical treatments, such as breathing machines or cardiopulmonary resuscitation (CPR). If my natural body functions fail, I would refuse treatments and choose to die naturally.

COVID-19 Diagnosis History

☐ I have been diagnosed with COVID-19 before.

Date(s) diagnosed: _____

Treated at: _____ by

_____

Additional information:

_____

_____

_____

_____

_____

_____

☐ I have *not* been diagnosed with COVID-19 before.

Primary Health Care Decision Maker - This is who I choose to speak for me in making health care decisions if I become unable to speak for myself.

Name: _____
Relationship: _____
Email: _____
Phone: _____

Secondary trusted decision maker (optional) - I choose the person listed below as my secondary trusted decision maker, who I choose to speak for me if my primary person is unable to serve.

Name: _____
Relationship: _____
Email: _____
Phone: _____

If you contract COVID-19 and require medical intervention, would you prefer to stay where you live or go to the hospital?

☐ Stay home
☐ Hospital care

What are your priorities?

(examples: staying alive no matter what, your family, comfort, etc.)

Additional notes:

_____

_____

_____

_____

_____

_____

_____

What are you most anxious about?

(examples: pain management, family care, isolation, dying, etc.)

What are some things that would bring you comfort?

(examples: friends, family, faith and spirituality, pets, hobbies, etc.)

Additional notes:

_____

_____

_____

_____

_____

_____

_____

List any other questions or concerns you want to bring up with your friend/family/provider:

_____

_____

_____

_____

_____

_____

_____

_____	_____	___/___/____
Printed name	Signature	Date

_____	_____	___/___/____
Primary decision maker	Signature	Date