PROVIDER IDENTIFICATION OF SURROGATE

(Tennessee)

I, _____ have identified _____

Print Name of Designated Physician — Print Name of Surrogate

as surrogate decision maker for _____, based on the criteria below.

Print Name of Patient

Surrogate identity and contact information:

Relation to patient: _____
Address: _____
_____
_____

Home phone: _____
Work phone: _____
Mobile phone: _____
Other: _____

Criteria considered in identification of surrogate (mark all that apply):

□ exhibits special care and concern for patient
□ familiar with patient's personal values/wishes
□ reasonably available
□ willing to serve
□ able to act in accordance with patient's known wishes/ best interests
□ regular contact with patient prior to/during illness
□ able to visit patient during illness
□ available for face-to-face contact with providers
□ able to participate in the decision-making process

_____ _____

Physician's signature* — Date/time

* If signed by a provider other than a physician, mark one: ☐ This patient has no designated physician
☐ The patient's designated physician is not reasonably available.

Any individuals in disagreement? □ Yes □ No. If Yes, please explain: _____

_____

Acceptance by Surrogate: I agree to serve as surrogate decision maker for the patient named above and am able and willing to make medical decisions on the patient's behalf.

_____ _____

Surrogate's signature — Date/time

If no surrogate can be identified, the designated physician may make health care decisions for the patient after obtaining one of the following signatures:

I certify that the designated physician has consulted with and obtained the recommendations of the facility's ethics mechanism:

_____
Signature of facility ethics representative
Date/time: _____

I am a physician not directly involved in the patient's care; I do not serve in a capacity of decision-making, influence, or responsibility over the designated physician; I am not under the designated physician's decision-making, influence, or responsibility; and I concur in the care plan for this patient.

_____
Signature of second physician
Date/time: _____