APPOINTMENT OF SURROGATE

(TENNESSEE)

I, _____ made the decision to appoint
Designated Physician

_____ as surrogate for
Name of Surrogate

_____.
Name of Patient

Surrogate Contact Information: Home: _____

Work: _____

Cell Phone: _____

Reasons for Appointment (check all that apply):

___ Knows patient's wishes
___ Knows patient's best interest
___ Had regular contact with patient
___ Available and willing to serve
___ Demonstrates care and concern
___ Visits patient regularly during illness
___ Engages in face-to-face contact with caregiver
___ Participates in decision making process

_____ _____
Physician Signature **Date/Time**

If designated physician is to act as surrogate, one of the following signatures must be obtained:

_____ **or** _____
Ethics Committee Representative Date **Concurring Second Physician Date**

Any individuals in disagreement? Yes ___ No ___
If yes, please explain _____

_____

_____

_____

ACCEPTANCE OF SURROGATE SELECTION

I accept the appointment as surrogate for _____
Patient
and understand I have the authority to make all medical decisions.

_____ _____
Signature of Surrogate **Date/Time**

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, May 3, 2005