

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):

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

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: _____