PATIENT HISTORY QUESTIONNAIRE

Patient Full Name: _____
Email Address: _____
Phone Numbers:
Home: _____
Cell: _____
Date of Birth: _____ Age: _____
Height: _____ Weight: _____
Gender: ☐ Female ☐ Male

Contact Person: _____
Contact Person Phone #:_____

Surgeon: _____ Surgery Date: _____

Pharmacy: _____
Address: _____
Phone: _____

Primary Care Physician: _____
Phone: _____
Fax: _____

Cardiologist: _____
Phone: _____
Fax: _____

Date of previous lab work: _____
Location: _____

Have you ever been treated at a Hoag Facility? ☐ Yes ☐ No If Yes, when? _____

Do you need an interpreter? ☐ Yes ☐ No If Yes, for what language? _____

ALLERGIES AND ALLERGIC REACTIONS:

Do you have any allergies? ☐ Yes ☐ No (Drugs, food, surgical tape, etc…)

Are you allergic to latex? ☐ Yes ☐ No If Yes, Reaction: _____

Are you allergic to metals? ☐ Yes ☐ No If Yes, Type/Reaction: _____

Allergies	Reaction

SURGERIES AND HOSPITALIZATIONS:

Have you ever had problems with anesthesia? ☐ Yes ☐ No If Yes, please explain: _____

Has anyone in your family ever had problems with anesthesia? ☐ Yes ☐ No

If Yes, please explain: _____

Will you accept blood products in case of emergency? ☐ Yes ☐ No

Surgeries/Hospitalizations	Year	Complications
1.		
2.		
3.		
4.		

Patient Name: _____ **Date of Birth:** _____

Please check if you had any of the following	Year	Where test and/or procedure was done
□ EKG		
□ Stress Test		
□ Echocardiogram (ultrasound of heart)		
□ Angioplasty / Stent Placement? □Yes □ No		
□ Cardiac surgery, please specify:		
□ Other procedure:		
□ Pacemaker/AICD (model/number):		Date pacemaker was last checked:

Please indicate past and current medical problems:

Cancer: Diagnosis date:_____
Type:_____
□ Radiation Therapy □ Chemotherapy Lymph Nodes removed? □ Yes □ No

Bleeding/Clotting Disorder:
□ Anemia
□ Bleeding Disorder/Blood Disease
Explain:_____
□ Blood Clots in □ Legs □ Lungs
□ Bruising
□ On blood thinner/anticoagulant
*Medication Name:*_____

Gland/Endocrine Problems:
□ Adrenal/Pituitary Problems
□ Current Prednisone or Steroid use
□ Diabetes: □Type 1 □ Type 2
□ Insulin Pump
□ Hypoglycemia
□ Hypo/Hyper Thyroid (circle)

Infection/Skin Problems:
□ Active Shingles
□ History C. Diff
□ History MRSA
□ History VRE
□ New Rash
□ Open wound
□ Current dental decay/abscess

Heart/Artery Problems:
□ Aneurysm
□ Angina/Chest Pain *Date:*_____
□ Arrhythmias (e.g. A-Fib)_____
□ Cardiomyopathy
□ Carotid Artery Disease
□ Congestive Heart Failure
□ Coronary Artery Disease
□ Family history of heart disease
□ Heart Attack *Date:*_____
□ Heart Murmur or Valve Problems
□ High Cholesterol
□ High Blood Pressure
□ Poor circulation in lower extremities

Lung Problems:
□ Asthma
□ Current inhaler use
□ Chronic cough
□ COPD/Emphysema
□ Current oxygen use at home
□ Pneumonia *Date*:_____
□ Tuberculosis
□ Sleep Apnea
Use CPAP? □Yes □ No
(***bring CPAP day of surgery***)
□ Shortness of breath when walking 2 blocks, climbing 1 flight of stairs or lying down

Neurologic:
□ Dementia/Alzheimer's
□ Fainting *Date:*_____
□ Headache/Migraine (circle)
□ Numbness
□ Neurostimulator
□ Paralysis/Weakness (circle)
□ Seizure *Last episode:*_____
□ Stroke *Date:*_____
□ TIA *Date:*_____
□ Multiple Sclerosis**
□ Myasthenia Gravis**
□ Parkinson**
****Bring medications day of surgery***

Liver/Digestive Problems:
□ Active Crohn's or Ulcerative Colitis
□ Hepatitis A B C (circle)
□ Hiatal Hernia
□ Liver Disease/Cirrhosis (circle)
□ Ulcers/GERD/Gastric Reflux (circle)
□ GI Bleeding
□ Diverticulosis/Diverticulitis

Pain:
□ Artificial joint *Location*:_____
□ Back/Neck Pain
□ Fibromyalgia
□ Lupus
□ Osteoarthritis/Rheumatoid Arthritis
□ Pain Pump
□ Chronic pain – *Doctor:*_____

Urine/Kidney Problems:
□ Dialysis *Last treatment date*:____
□ Difficulty Urinating
□ Penile Prosthesis
□ Prostate Disease
□ Urinary Tract Infection (frequent)_____
□ Prior difficulty with catheter insertion
Name of Urologist: _____

Patient Name: _____ **Date of Birth:** _____

Have you had any of the following vaccines?

Flu vaccine? □ Yes □ No What year? _____

Pneumonia vaccine? □ Yes □ No What year? _____ ☐ Pneumovax ☐ Prevnar 13

Smoking History:

Have you ever smoked? □ Yes □ No For how many years? _____ Year Quit: _____

Do you currently smoke? □ Yes □ No For how many years? _____

How many cigarettes per day on average? _____

Have you smoked in the past 12 months? □ Yes □ No

Alcohol History:

Do you drink alcohol? □ Yes □ No

How much alcohol do you consume and how often? _____

Drug History:

Do you use recreational drugs? □ Yes □ No Last used: _____

What kind of recreational drugs do you use? _____

For Female Patients:

Any possibility of pregnancy? □ Yes □ No Date of last menstrual period: _____

Social History:

Do you live alone? □ Yes □ No With whom do you live? _____

Do you have stairs? □ Yes □ No

Will there be someone to assist you at home after discharge from the hospital? □ Yes □ No

Are you presently employed or retired? _____ What type of work do you do? _____

Do you have any special needs or concerns? _____

Do you wear contacts? □ Yes □ No

Do you wear hearing aids? □ Yes □ No

Do you have caps, bridges, dentures or loose teeth? □ Yes □ No

Do you exercise? □ Yes □ No Type: _____ Duration/Frequency: _____

[Patient/Parent/Conservator/Guardian] [Date] [Time] [If completed by other than patient, indicated relationship]

[Reviewed by Navigator] [Date] [Time]

[Reviewed by Assessment Nurse] [Date] [Time] [Reviewed by Procedure Nurse] [Date] [Time]

[Reviewed by PACU Nurse] [Date] [Time] [Reviewed by Discharge Nurse] [Date] [Time]

HOAG ORTHOPEDIC INSTITUTE

PATIENT STATED HOME MEDICATION LIST

Acknowledgement: I confirm that this is a complete and accurate list of my current medications to the best of my knowledge, including prescription and over the counter drugs. I agree to discontinue all herbal and nutritional supplements 7 days prior to surgery. I understand that healthcare providers will make medical decisions based on this information.

BRING THIS FORM WITH YOU TO HOI

☐ **Check this box if not on any home medications**. _____
(Signature of Patient/Responsible Person)

Describe allergies and reactions:

Completed by: _____
Source of Medication History: _____ Date/Time: _____

	Medication	Dose	Route	Frequency	Reason for Taking
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

HOAG ORTHOPEDIC INSTITUTE

ACTIVITY ASSESSMENT

Patient Name: _____ DOB: _____

Surgeon Name: _____ Date of Surgery: _____

Please answer questions below regarding your ability to do these activities as if you did not have pain or mobility issues. We want to know how well your heart and lungs function.

		Please Check One:	
1.	Can you take care of yourself (eating, dressing, bathing or using the toilet)?	☐ Yes (2.75)	☐ No (0)
2.	Can you walk indoors, such as around your house?	☐ Yes (1.75)	☐ No (0)
3.	Can you walk a block or two on level ground?	☐ Yes (2.75)	☐ No (0)
4.	Can you climb a flight of stairs or walk up a hill?	☐ Yes (5.50)	☐ No (0)
5.	Can you run a short distance?	☐ Yes (8.00)	☐ No (0)
6.	Can you do light housework around the house, such as dusting or washing dishes?	☐ Yes (2.70)	☐ No (0)
7.	Can you do moderate work around the house, such as vacuuming, sweeping floors or carrying in groceries?	☐ Yes (3.50)	☐ No (0)
8.	Can you do heavy work around the house, such as scrubbing floors or lifting and moving heavy furniture?	☐ Yes (8.00)	☐ No (0)
9.	Can you do yard work such as raking leaves, weeding, or pushing a power mower?	☐ Yes (4.50)	☐ No (0)
10.	Can you have sexual relations?	☐ Yes (5.25)	☐ No (0)
11.	Can you participate in moderate recreational activities such as golf, bowling, dancing, doubles tennis, or throwing a baseball or football?	☐ Yes (6.00)	☐ No (0)
12.	Can you participate in strenuous sports, such as swimming, singles tennis, football, basketball or skiing?	☐ Yes (7.50)	☐ No (0)

Patient Signature: _____ Date: _____

Adapted from the Duke Activity Scale (DASI) = sum of "Yes" replies _____
VO2peak = (0.43 x DASI) + 9.6
VO2peak = _____ ml/kg/min ÷ 3.5 ml/kg/min = _____ METS

HOAG ORTHOPEDIC INSTITUTE

PRE PROCEDURE PATIENT SELF ASSESSMENT - SLEEP APNEA SCREEN

INSTRUCTIONS: Please answer YES or NO to the questions below:

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors? ☐ Yes ☐ No
2. Do you often feel tired, fatigued or sleepy during the daytime? ☐ Yes ☐ No
3. Has anyone observed you stop breathing during your sleep? ☐ Yes ☐ No
4. Are you being, or have been, treated for high blood pressure? ☐ Yes ☐ No
5. Is your body mass index ≥ 35 (weight in lbs/height in inches^2)? ☐ Yes ☐ No
6. Are you > 50 years old? ☐ Yes ☐ No
7. Is your neck circumference ≥ 17 inches in men; ≥ 16 inches in women? ☐ Yes ☐ No
8. Are you male? ☐ Yes ☐ No
9. Have you ever had radiation to the neck? ☐ Yes ☐ No

If you answer YES to *three or more criteria* above, speak to your primary care physician, surgeon or the nurse.
If you already have known **sleep apnea**, **bring CPAP headgear and mask** to hospital for your procedure.

☐ I currently use CPAP machine and my current setting is: _____

_____ _____ _____ A.M./P.M. _____
[Signature of Patient/Parent/Conservator/Guardian] [Date] [Time] [If signed by other than patient, indicate relationship]

Please see chart below to determine your BMI. Circle your height and weight.

BODY MASS INDEX (BMI) weight in pounds

	Ideal			Overweight		Obese					Morbidly Obese					
BMI ➔	**20**	**22**	**24**	**26**	**28**	**30**	**32**	**34**	**36**	**38**	**40**	**42**	**44**	**46**	**48**	**50**
4' 10"	96	105	115	124	134	144	153	163	172	182	191	201	211	220	230	239
4' 11"	99	109	119	129	139	149	158	168	178	188	198	208	218	228	238	248
5' 0"	102	113	123	133	143	154	164	174	184	195	205	215	225	236	246	256
5' 1"	106	116	127	138	148	159	169	180	191	201	212	222	233	243	254	265
5' 2"	109	120	131	142	153	164	175	186	197	208	219	230	241	252	262	273
5' 3"	113	124	135	147	158	169	181	192	203	215	226	237	248	260	271	282
5' 4"	117	128	140	151	163	175	186	198	210	221	233	245	256	268	280	291
5' 5"	120	132	144	156	168	180	192	204	216	228	240	252	264	276	288	300
5' 6"	124	136	149	161	173	186	198	211	223	235	248	260	273	285	297	310
5' 7"	128	140	153	166	179	192	204	217	230	243	255	268	281	294	306	319
5' 8"	132	145	158	171	184	197	210	224	237	250	263	276	289	303	316	329
5' 9"	135	149	163	176	190	203	217	230	244	257	271	284	298	311	325	339
5' 10"	139	153	167	181	195	209	223	237	251	265	279	293	307	321	335	348
5' 11"	143	158	172	186	201	215	229	244	258	272	287	301	315	330	344	358
6' 0"	147	162	177	192	206	221	236	251	265	280	295	310	324	339	354	369
6' 1"	152	167	182	197	212	227	243	258	273	288	303	318	334	349	364	379
6' 2"	156	171	187	203	218	234	249	265	280	296	312	327	343	358	374	389
6' 3"	160	176	192	208	224	240	256	272	288	304	320	336	352	368	384	400
6' 4"	164	181	197	214	230	246	263	279	296	312	329	345	361	378	394	411
6' 5"	169	186	202	219	236	253	270	287	304	320	337	354	371	388	405	422
6' 6"	173	190	208	225	242	260	277	294	312	329	346	363	381	398	415	433

Enter electronic order, call Irvine Respiratory on Cisco x73835

_____ _____ _____ _____
[Print Name of Pre-Procedure RN] [RN Signature] [Date] [Time]

_____ _____ _____ _____
[Print Name of Post-Procedure RN] [RN Signature] [Date] [Time]

HOAG ORTHOPEDIC INSTITUTE

BENIGN PROSTATIC HYPERTROPHY (BPH) SYMPTOM SCORE QUESTIONNAIRE (For Male Patients Only)

Patient Name: _____ Date of Birth: _____

Please circle what best describes.	Not at all	Less than 1-5 times	Less than half the time	About half the time	More than half the time	Almost always
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary system?	0	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5 times
Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5
					TOTAL:	

SCORE: 0-7 Mild 8-19 Moderate 20-35 Severe

The possible total runs from 0-35 points with the high scores indicating more severe symptoms.
Scores less than 7 are considered mild and generally do not warrant treatment.

Disclaimer: This material is provided for information purposes only and is not a substitute for a consultation. You should consult with a Urologist regarding your specific symptoms or medical condition.

Signature: _____ Date Completed: _____

FORM 3-1

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

9617	Patient's Name:
 [1214]	MR#

PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

AGENT'S AUTHORITY:

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

_____

(Initial here)

OR

My agent's authority to make health care decisions for me takes effect immediately.

_____

(Initial here)

AGENT'S OBLIGATION:

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT'S POSTDEATH AUTHORITY:

My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR:

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2 – INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END OF LIFE DECISIONS:

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life:

_____
(Initial here)

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

Choice To Prolong Life:

_____
(Initial here)

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed.)

OTHER WISHES:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

_____

(Add additional sheets if needed.)

PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

I. Upon my death:

I give any needed organs, tissues, or parts. _____
(Initial here)

OR

I do *not* authorize the donation of any organs, tissues or parts. _____
(Initial here)

OR

I give the following organs, tissues, or parts only: _____

_____

_____
(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete II. and III.

My gift is for the following purposes:

Transplant _____ *(Initial here)* Research _____ *(Initial here)*

Therapy _____ *(Initial here)* Education _____ *(Initial here)*

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.

Yes _____ *(Initial here)* No _____ *(Initial here)*

2. My donated tissue may be used for applications outside of the United States.

Yes _____ *(Initial here)* No _____ *(Initial here)*

3. My donated tissue may be used by for-profit tissue processors and distributors.

Yes _____ *(Initial here)* No _____ *(Initial here)*

(Health and Safety Code Section 7158.3)

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician:

Telephone: _____

Address: _____

_____

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician:

Telephone: _____

Address: _____

_____

PART 5 – SIGNATURE

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

SIGNATURE:

Sign and date the form here:

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Print name: _____
(patient)

Address: _____

_____

STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

SECOND WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

ADDITIONAL STATEMENT OF WITNESSES:

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of the document.

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California)

County of _____)

)

On *(date)* _____ before me, *(name and title of the officer)* _____ _____ personally appeared *(name(s) of signer(s))* _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature: _____ [Seal]
(notary)

PART 6—SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient advocate or ombudsman)

Print name: _____
(patient advocate or ombudsman)

Address: _____

_____