Surgery Schedule, Pre-op Appointments and Testing

Your surgery:

Scheduled surgery date: _____
Arrival time: _____
Location: Hoag Hospital, Sue & Bill Gross Women's Pavilion, One Hoag Drive, Newport Beach, CA 92663
Surgeon: _____
Surgery scheduling: 949-764-8258 or 949-650-3350

The following tests or procedures need to be completed prior to your surgery (as required by your surgeon):

- ☐ EKG
- ☐ Blood work
- ☐ Urine sample
- ☐ Carotid ultrasound
- ☐ Chest X-ray
- ☐ Coronary angiogram
- ☐ Echocardiogram
- ☐ CTA or CT scan
  - Requires fasting for 2 hours before your test; you may drink water if needed for taking oral meds
- ☐ Pulmonary function test/pulmonary screening
  - **No smoking**, **alcohol, chocolate or caffeine** at least **12 hours before your test**; decaf coffee, decaf tea and herbal tea are okay
  - If possible, do not use your inhaler on the day of the test. You can bring your inhaler and use it after you have completed the test.
- ☐ Other: _____

Your pre-op appointment (for education and testing):

This appointment is usually scheduled **7-10 days** before your surgery and takes **3-4 hours**.
Scheduled pre-op appointment date: _____
Arrival time: _____
Location: Hoag Hospital, Jeffrey M. Carlton Heart & Vascular Institute, Building #31, Newport Beach, CA 92663

- You may receive an automated call informing you of a scheduled appointment for a pulmonary, vascular or radiology test; please disregard this call and arrive at your scheduled arrival time (listed above)

Pre-operative Surgery Pack Instructions

Please review the following documents:

Map
Your pre-op testing and teaching appointment with either Marita Fabros or Sarah Schmidt will be held at Jeffrey M. Carlton Heart and Vascular Institute, Building 31 (across parking lot P2).

Patient Medication List
You need to complete an **updated list of your current medications** for your pre-op visit. Aside from your regular prescribed medications, include over the counter supplements, vitamins, inhalers, nasal sprays, eye drops and topical agents that you are taking or using before your surgery.

Pulmonary Function Testing Questionnaire

- Answer the questions and sign below (patient signature) with date and time you complete this form.
- Your answer to question #1: Pre-op
- Your answer to question #6 (history of heart disease): Yes (if you are going for heart surgery or procedure)
- Your answer to question # 11 (medications): See medication list

Advance Healthcare Directive (AHCD)

- It is a state law that we offer you an Advance Health Care Directive (a copy is in your packet) It is a good idea to have one completed and on file at Hoag for your surgery.
- Part 1 of the form lets you choose and assign your designated agent to make health care decisions for you if you become incapable of making your own decisions. A designated agent can either be your spouse, significant other, family member, relative or a friend.
- Part 2 of the form lets you document specific instructions about any aspect of your health care.
- If you already have a health care directive at home (it can be a part of your living will or trust) please make a copy and bring it to your pre-op appointment to be scanned into the hospital's electronic system.
- It is not mandatory to complete an advanced health care directive, but it is recommended to avoid conflict of interest on decision-making among your loved ones.
- Make sure you follow the instructions carefully when completing this form. Part 5 of this form is when you need to sign and date your portion. You are required either to have 2 witnesses sign this directive or notarized by a notary to make this form a legal document. Your witnesses can not be blood relatives.

SF-12 Health Survey

- Only patients scheduled for mitral valve repair surgery need to complete this form.

Before your pre-op appointment:

- ☐ Read the materials in your pre-op surgery instruction folder
- ☐ Complete the forms (as required) in your pre-op surgery instruction folder and bring them with you to your pre-op appointment
- ☐ Watch the 4 pre-op educational videos located at hoag.org/cv-appointment
- ☐ If you are having valve surgery (including aortic valve, mitral valve and tricuspid valve), you will need to **obtain dental clearance for surgery from your dentist**
    - Your dentist will check for teeth and gum infections; please see the dental clearance form in your pre-op surgery instruction folder for more information
- ☐ Obtain necessary clearance(s) for surgery from other specialist(s):

  _____
- ☐ Your pharmacy will receive an electronic prescription for a **nasal ointment (Mupirocin)**. Accept and pick up your nasal ointment (Mupirocin) prescription from your pharmacy.

During your pre-op appointment:

You may bring **1 person** with you during your pre-op appointment, preferably your **main caregiver** to attend and listen to this educational session.

- Part 1 - Pre-op clinic and education:
    - ☐ Urine sample – please inform your pre-op nurse if you need to void upon arrival so she can instruct you on how to obtain your urine sample correctly.
    - ☐ Blood work
    - ☐ EKG
    - ☐ Your pre-op nurse will review your medication list and pre-op instructions in detail, including the skin prep, nasal treatment instructions and how to use an incentive spirometer (breathing exercise device).

- Part 2 – Pre-op tests: we will direct you to the location(s) for any test(s) your surgeon ordered
    - ☐ Carotid ultrasound – vascular department
    - ☐ Coronary angiogram – cath lab
    - ☐ Echocardiogram – echo department
    - ☐ Pulmonary function test/pulmonary screening - pulmonary department
    - ☐ Chest X-rays – radiology department
    - ☐ CTA or CT scan – radiology department or Hoag Health Center Newport Beach (510 Superior Ave, Suite 100).
    - ☐ Others (not listed above) _____

After your pre-op appointment:

- ☐ Within 5 days before your surgery, your pre-op nurse will schedule your **COVID-19 test** at Hoag Health Center Newport Beach (510 Superior Ave., Suite 110) or Hoag Health Center Irvine (16305 Sand Canyon Ave, Suite 270). You will receive a phone notification on when and where your test is scheduled.
- ☐ Confirm you provided surgery clearances as needed (ex: dental clearance for surgery)

Regarding blood donation

Blood may be needed during or after your surgery. Generally, our surgeons utilize blood donated by volunteer donors to our Blood Donor Center. The blood from the Donor Center is tested for infectious diseases and our surgeons feel safe to utilize them.

Although some patients choose to donate their own blood prior to surgery, others should not donate because of their health status or the timing of their surgery. Donating blood before surgery can be expensive and time consuming. As a rule of thumb, do not donate blood close to your surgery date as this will lower your blood count and may make you anemic. For example, after donating **a pint of blood** your body will need **4-8 weeks** to fully replenish your red blood cells.

If you are still interested in donating your own blood in preparation for your surgery, please discuss this with your surgeon and make arrangements ahead of time.

Regarding herbals/over the counter (OTC) supplements

Many herbals (see list) and OTC supplements have **possible side-effects that can interfere with anesthesia** and can also **increase the risk of bleeding**. Your surgeon may recommend that you stop taking these supplements **1-2 weeks** before your surgery.

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PULMONARY FUNCTION TESTING QUESTIONNAIRE

To our patient: Please answer the questions below and sign your name at the end. Thank you!

1. Reason for today's test: _____
2. Have you ever smoked? ☐ Yes ☐ No
   If yes, what did you smoke? (check all that apply) ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Other: _____
   How many years did you smoke? _____ How many packs a day did/do you smoke? _____
   When did you quit smoking? _____
3. Do you get short of breath when:
   - Sitting ☐ Yes ☐ No
   - Walking normally ☐ Yes ☐ No
   - Climbing stairs ☐ Yes ☐ No
4. Do you have a daily cough? ☐ Yes ☐ No
5. Do you frequently cough-up mucous ☐ Yes ☐ No
6. Have *you* ever had a history of:

Emphysema	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	Bronchiectasis	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No

7. Do you have Sleep Apnea: ☐ Yes ☐ No
8. Have you had recent surgery of the chest or abdomen? ☐ Yes ☐ No
9. Have you ever had a breathing tube in your windpipe for surgery or to help you breathe? ☐ Yes ☐ No
10. Have you ever been exposed to dust, fumes, chemicals in a hazardous manner while at work or at home?
    ☐ Yes ☐ No If yes, please list your exposure: _____
11. What medications are you currently taking? _____
    _____
12. Have you ever had radiation or chemotherapy? ☐ Yes ☐ No
    If yes, please list medication or area of radiation: _____

_____ _____ _____ A.M./P.M.
[Patient Signature] [Date] [Time]

Date: _____ Ordering Physician: _____
BP: _____ HR: _____ SPO_2 _____% on_____ THB: _____ % CO _____ SAO_2 _____%
PRE-OP For: _____ Date of surgery: _____
PRE-OP Education: ☐ Intubation/ET Tube ☐ Incentive Spirometry ☐ Splinting ☐ Coughing/Deep breathing
Patient Position: _____ Repeatable Test? ☐ Yes ☐ No
RCP Comments: _____
RCP Print Name: _____ RCP Signature: _____

PATIENT HEALTH HISTORY

PS 4117 Rev 01/31/19

[4426]

hoag
Heart & Vascular Institute

Note:
Only mitral valve repair patients need to complete this form

One Hoag Drive, P.O. Box 1600
Newport Beach, CA 92658
Barbara Eklund-Horn, MSN, RN
Valve Clinic Coordinator
Phone: (949)764-5725 Fax: (949)764-1493

VALVE CLINIC SF12 PATIENT QUESTIONNAIRE
PRE-OPERATIVE

Patient Name: _____

1. In general, would you say your health is:
   1-Excellent 2-Very Good 3-Good 4-Fair 5-Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
   1-Yes, limited a lot 2-Yes, limited a little 3-No, not limited at all

3. Climbing several flights of stairs.
   1-Yes, limited a lot 2-Yes, limited a little 3-No, not limited at all

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like.
   1-All of the time 2-Most of the time 3-Some of the time 4-A little of the time 5-None of the time

5. Were limited in the kind of work or other activities.
   1-All of the time 2-Most of the time 3-Some of the time 4-A little of the time 5-None of the time

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems such as depression or anxiety.

6. Accomplished less than you would like.
   1-All of the time 2-Most of the time 3-Some of the time 4-A little of the time 5-None of the time

hoag
Heart & Vascular Institute

Patient Name: _____

7. Did not do activities as carefully as usual.
   1-All of the time 2-Most of the time 3-Some of the time 4-A little of the time 5-None of the time

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
   1-Not at all 2-A little bit 3-Moderately 4-Quite a bit 5-Extremely

These questions are about how you feel, and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

9. Have your felt calm and peaceful?
   1-All of the time 2-Most of the time 3-Some of the time 4-A little of the time 5-None of the time

10. Do you have a lot of energy?
    1-All of the time 2-Most of the time 3-Some of the time 4-A little of the time 5-None of the time

11. Have you felt downhearted and depressed?
    1-All of the time 2-Most of the time 3-Some of the time 4-A little of the time 5-None of the time

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities like visiting friends or relatives?
    1-All of the time 2-Most of the time 3-Some of the time 4-A little of the time 5-None of the time

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Print Name – Legal Representative: _____

PATIENT LABEL

NEWPORT CARDIAC & THORACIC SURGERY
Jeffrey M. Carlton, Hoag Heart & Vascular Institute
Telephone (949) 764-8258 - FAX (949) 764-1493

ANTHONY D. CAFFARELLI, M.D.
ASAD A. SHAH, MD
DARYL P. PEARLSTEIN, M.D.
TIMOTHY M. LEE, M.D., M.S.

Dental Evaluation: Instructions to the Patient

- Dental infections can allow bacteria into the blood stream, which can infect the heart valves.
- For anyone undergoing heart valve repair/ replacement/ TAVR or Mitra-Clip, we require that they undergo a dental exam and obtain clearance within 6 months of surgery.
- Please contact your dentist's office to be evaluated as soon as possible.
- **The attached form needs to be completed by your dentist and faxed back to us no later than one week prior to your scheduled surgery, or your surgery is at risk of being postponed.**

Note:
Dental clearance is only necessary for heart valve surgery patients

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ASAD A. SHAH, MD
DARYL P. PEARLSTEIN, M.D.
TIMOTHY M. LEE, M.D.

Heart Valve Surgery Dental Evaluation

Re: _____ DOB: _____

Dear Dentist,

Our mutual patient is scheduled to undergo heart valve surgery at Hoag Hospital. To decrease the incidence of infective endocarditis we require a careful preoperative dental evaluation so that required dental treatment may be completed whenever possible before cardiac valve surgery, per American Heart Association Guidelines.

Clearance prior to valve surgery: Please exam the patient's mouth and indicate below if there are any identifiable sources of infection in the oral cavity.

If dental work is required for surgical clearance: We request these procedures be performed **with appropriate antibiotic protection**. Please contact the patient's cardiologist if you require medical clearance for dental procedures or need prescription for appropriate prophylactic antibiotic.

After valve surgery: We prefer that the patient does not undergo elective dental procedures (such as dental cleaning) for **three months** following valve surgery. Of course, urgent dental issues should be treated as needed with antibiotic coverage.

AHA Guideline: Prevention of Infective Endocarditis. Circulation. 2007; 116:1736-1754

TO BE COMPLETED BY DENTIST & FAXED TO 949-764-1493 AS SOON AS POSSIBLE

On _____ I conducted a dental examination on_____
(Appt Date) (Patient's Name)

From the dental perspective this patient is: (Please check the appropriate box).

☐ **"Cleared"** I saw no indication of any gingival, periodontal or endodontic infections. From the dental aspect, I see no reason to delay their heart valve surgery.

☐ **"Not cleared"** I saw active gingival, periodontal or endodontic infections which, in my opinion, could place the patient at increased risk for endocarditis. I recommend the following dental work be done prior to their heart valve surgery:

_____

_____

_____ _____
Dentist's name (Please print) Dentist signature

_____ _____ _____
Date Phone Number Fax number

ADVANCE HEALTH CARE DIRECTIVE

Explanation
You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

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 a different person to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

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 your organs, tissues, and parts; 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.

Name of Patient: _____

Date of Birth: _____

Part 1 – Power of Attorney for Health Care

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.

Designation of Agent:

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

Name of person you choose as agent: _____

Address: _____

_____

Telephone: _____

(home phone) *(work phone)* *(cell)*

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 alternate agent:

Name of person you choose as alternate agent: _____

Address: _____

_____

Telephone: _____

(home phone) *(work phone)* *(cell)*

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 must 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 donate my organs, tissues, and parts, 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 agent whom I have named.

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:
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,

_____
(Initial here)

OR

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

_____
(Initial here)

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, Tissues, and Parts at Death (*Optional)*

Upon my death:

I give my organs, tissues, and parts. _____
(Initial here to indicate yes)

By initialing this line, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

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)

My donation is for the following purposes (strike any of the following you do not want):

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

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

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines: _____
_____

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 _____ No _____
   (Initial here) *(Initial here)*
2. My donated tissue may be used for applications outside of the United States.
   Yes _____ No _____
   (Initial here) *(Initial here)*
3. My donated tissue may be used by for-profit tissue processors and distributors.
   Yes _____ No _____
   (Initial here) *(Initial here)*

If I leave Part 3 blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or on page 3 of this form.)

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.

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: _____

Civil Code Section 1189; Health and Safety Code Section 7158.3; Probate Code Section 4701