COLORADO
CARE PLANNING

www.coloradocareplanning.org

ADVANCE CARE PLANNING WALLET CARD

Keep this information up to date! Review every 6 months!

Name____________________________________

Date of Birth_______________________________

Address_________________________________

____

Doctor__________________________________

Doctor's Phone Number (______)________________

Preferred Hospital_____________________________

Blood Type_____ MedicalConditions/Allergies__________

____

EMERGENCY CONTACTS

Healthcare Decision Maker Name:

____

Phone Number (________)____________________

Local Emergency Contact (if different):

____

Phone Number (________)____________________

COMPLETED ADVANCE DIRECTIVES

			Located or On File At
Medical Durable Power of Attorney	Yes	No	____________
Living Will	Yes	No	____________
MOST Form	Yes	No	____________
Five Wishes	Yes	No	____________
CPR Directive	Yes	No	____________

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