GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

SUBSTITUTED CONSENT FOR HEALTH CARE DECISIONS

For: ________________________________________________

Name of individual

Relationship to the above-named individual:

☐ I am a family member/relative of this individual. My relationship to this individual is ________________________________________________.

☐ I am a pastor, clergy member or priest or other religious official that is involved with this individual’s life. My relationship to this individual is ________________________________________________.

☐ I am a close friend of this individual. My relationship to this individual is ________________________________________________.

I am willing to provide substituted consent for health care decisions for this individual. I am providing my contact information below so that I can be kept informed of this individual’s medical needs. I believe that I have had sufficient contact with this individual to be familiar with his/her activities, health care personal beliefs, and that I am thus qualified to make decisions on his/her behalf. I understand that, in making decisions on behalf of this individual, I will consider: the individual’s current diagnosis and prognosis with and without the treatment at issue; expressed preferences regarding the type of treatment at issue; relevant religious and moral beliefs and personal values; behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally; reactions to the provision, or withholding or withdrawal of similar treatment to another individual; and expressed concerns about the effect on family or intimate friends of the individual if treatment were provided, withheld or withdrawn.

Please print or type the following:

Name: ________________________________________________

Address: ________________________________________________

City/State/Zip Code: ________________________________________________

Telephone Number(s): ________________________________________________

________________________________________________________________________

______________________________________________________
Notary Public

Sworn to and subscribed to before me this ______ day of_______________________ 20___.

Attachment 6- Substitute Decision-Making for Non-Emergency Needs Policy
My commission expires on: ________________________________