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PHYSICIAN ACTIVATION OF HEALTH CARE PROXY

DOCUMENTATION OF PATIENT INCAPACITY

I, _____, have on the date cited below,
(Name of Physician, printed)

determined that _____
(Name of Patient, printed)

lacks the capacity to make or communicate decisions relative to his/her medical care. This determination is made in accordance with accepted standards of medical judgment and pursuant to M.G.L. c.102D, the Massachusetts Health Care Proxy Law. The cause, nature, extent, and probable duration for the patient’s incapacity are described below:

Inability to understand and make appropriate medical decisions due to _____

Inability to effectively communicate due to _____

The probable duration of this incapacity is: Temporary Permanent

The proxy agent is _____.
(Name of Agent/Health Care Proxy)

Note: If the patient’s lack of capacity is due to mental illness or developmental disability, the physician signing the form must have, or consult with a physician who has specialized training or experience in diagnosing or treating such conditions.

Date

Signature of Physician