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

05/2014