

**BATON ROUGE HEALTH SERVICES COMMUNITY
ADVANCED SELECTION OF HEALTH CARE SERVICES PROVIDER**

I, _____, currently residing at _____
_____, Ohio _____, do hereby choose **BATON ROUGE HEALTH SERVICES COMMUNITY** as my health care provider for all of my skilled nursing, assisted living, outpatient rehab, or adult day care services. This document allows for pre-need selection in the event that I am unable to communicate or otherwise make my wishes known to my family and/or sponsor/legal representative(s) when they are faced with decisions that involve my health, safety and/or well-being.

_____ By placing an 'x' in the box and my initials on the line adjacent, I authorize **Baton Rouge Health Services Community** to forward this signed document to my Primary Care Physician and hospital of choice as indicated below. Furthermore, I hereby authorize these providers to contact **Baton Rouge Health Services Community** to initiate my transfer for health care services on their medical campus as availability or need exist.

SIGNATURE _____
DATE

If signature is made by 'x', then two (2) witnesses are required

PRINTED NAME STREET ADDRESS CITY/STATE/ZIP PHONE NUMBER

WITNESS SIGNATURE _____
DATE

PRINTED NAME STREET ADDRESS CITY/STATE/ZIP PHONE NUMBER

WITNESS SIGNATURE _____
DATE