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Advance Directive

Durable Power of Attorney for Healthcare (Patient Advocate Designation)

Introduction

This document provides a way for you to create a Durable Power of Attorney for Healthcare (Patient Advocate Designation) and other documentation that will meet the basic requirements for this state. This Advance Directive (AD) allows you to appoint a person (and alternates) who shall take reasonable steps to follow the desires and instructions indicated within this document, or in other written or spoken treatment preferences.

The person you appoint is called your **Patient Advocate**. This document gives your consent to allow your Patient Advocate to make decisions *only when two physicians, or a physician and a licensed psychologist, have determined you are unable to make your own decisions*. Every resident age 18 and over should appoint a Patient Advocate, as accidents can happen to anyone, at any time.

Note: This AD does *not* give your Patient Advocate permission to make your *financial* or other *business* decisions.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your Patient Advocate(s).**
If you do not closely involve your Patient Advocate(s), and you do not make a clear plan together, your views and values may not be fully followed because they will not be understood.

This document was developed to meet the legal requirements of Michigan. It is not designed to replace the counsel of your attorney.

This is an Advance Directive for *(print legibly)*:

Name: _____ Date of Birth: _____ Last 4 digits of SSN: _____

Telephone: Primary (Cell ☐) _____ Secondary (Cell ☐) _____

Address: _____

City/State/Zip: _____

Where I would like to receive hospital care (whenever possible): _____

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Advance Directive

My Patient Advocate

When either two physicians or a physician and licensed psychologist determine I am unable to make health care decisions, this document names the person(s) I have chosen to be my Patient Advocate(s). They shall take reasonable steps to carry out my treatment preferences. I understand that it is important to regularly talk with my Patient Advocate(s) about my health and treatment preferences. I hereby give my Patient Advocate(s) permission to share a copy of this document with other doctors, hospitals and health care providers that provide my medical care.

☐ Based on my expressed religious beliefs, I would prohibit having an examination for determination to participate in medical decision-making by a doctor, licensed psychologist or another medical professional. Instead, I request the determination for incapacity be made in the following manner:

_____

_____

_____

☐ If I leave this section blank, I am leaving the evaluation decision to my Patient Advocate(s)

(NOTE: If your wishes change**, you may revoke your Patient Advocate Designation at any time and in any manner sufficient to communicate an intent to revoke. **It is recommended that you complete a new Advance Directive and give it to everyone who has a previous copy).

The person I choose as my Patient Advocate is

Name: _____ Relationship: _____

Telephone: Primary (Cell ☐) _____ Secondary (Cell ☐): _____

Address: _____

City/State/Zip Code: _____

First Alternate (Successor) Patient Advocate (strongly advised)

If Patient Advocate above is not capable or willing to make these choices for me, then I designate the following person to serve as my Patient Advocate.

Name: _____ Relationship: _____

Telephone: Primary (Cell ☐) _____ Secondary (Cell ☐) _____

Address: _____

City/State/Zip Code: _____

Second Alternate (Successor) Patient Advocate (strongly advised)

If the Patient Advocates named above are not capable or willing to make these choices for me, then I designate the following person to serve as my Patient Advocate.

Name: _____ Relationship: _____

Telephone: Primary (Cell ☐) _____ Secondary (Cell ☐) _____

Address: _____

City/State/Zip Code: _____

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Advance Directive

Signature Page

I give my Patient Advocate express permission to **make decisions to withhold or withdraw treatment which would allow me to die,** and I acknowledge **such decisions could or would allow my death**

I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life- sustaining treatment, such as, but not limited to: ventilator (breathing machine), cardiopulmonary resuscitation (CPR), nutritional tube feedings, intravenous (IV) hydration, kidney dialysis, blood pressure or antibiotic medications—and hereby give my Patient Advocate(s) express permission to help me achieve my goals of care. This may include beginning, not starting, or stopping treatment(s). I understand that such decisions could or would allow my death.
Medications and treatment intended to provide comfort or pain relief shall not be withheld or withdrawn.

____ I agree with this statement ____ I do NOT agree with this statement

This Advance Directive includes the following sections: Spiritual/Religious Preferences; End of Life Care; Anatomical Gift(s) - Organ/Tissue/Body Donation; Autopsy Preference; Mental Health Treatment, & Treatment Preferences (Goals of Care).

Signature of the Individual in the Presence of the Following Witnesses

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind.

Signature: _____ Date: _____

Address: _____

City/State/Zip Code: _____

Signatures of Witnesses

I know this person to be the individual identified as the "Individual" signing this form. I believe him or her to be of sound mind and at least eighteen (18) years of age. I personally saw him or her sign this form, and I believe that he or she did so voluntarily and without duress, fraud, or undue influence. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not the Patient Advocate or alternate Patient Advocate appointed by the person signing this document.
- Not the patient's spouse, parent, child, grandchild, sibling or presumptive heir.
- Not listed to be a beneficiary of, or entitled to, any gift from the patient's estate.
- Not directly financially responsible for the patient's health care.
- Not a health care provider directly serving the patient at this time.
- Not an employee of a health care or insurance provider directly serving the patient at this time.

Witness Number 1: ☐ I meet the witness requirements stated above

Signature: _____ Date: _____

Print Name: _____

Address: _____

City/State/Zip Code: _____

Witness Number 2: ☐ I meet the witness requirements stated above

Signature: _____ Date: _____

Print Name: _____

Address: _____

City/State/Zip Code: _____

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Accepting the Role of Patient Advocate

Acceptance

The person named above has asked you to serve as his or her Patient Advocate (or as an alternate Patient Advocate). Before agreeing to accept the Patient Advocate responsibility and signing this form, please:

1. *Carefully read the **Introduction (1A)**, "The Advance Care Planning Process" (separate document), and this completed **Patient Advocate Designation Form**, (including any optional **Preferences** listed on pages 6A-9A). Also, take note of any **Treatment Preferences** ([Goals of Care], pages 1B-2B) and/or Statement of Treatment Preferences that may be attached. These documents will provide important information that you will use in discussing the person's preferences and in potentially acting as this person's Patient Advocate.*
2. *Discuss, in detail, the person's values and wishes, so that you can gain the knowledge you need to allow you to make the medical treatment decisions he or she would make, if able.*
3. *If you are at least 18 years of age and are willing to accept the role of Patient Advocate, read, sign and date the following statement.*

I accept the person's selection of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the person as indicated within this "Advance Directive: My Patient Advocate" document or in other written or spoken instructions from the person. I also understand and agree that, according to Michigan law:

a. This appointment shall not become effective unless the patient is unable to participate in medical or mental health treatment decisions, as applicable.
b. I will not exercise powers concerning the patient's care, custody, medical or mental health treatment that the patient – if the patient were able to participate in the decision – could not have exercised on his or her own behalf.
c. I cannot make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant, if that would result in the patient's death, even if these were the patient's wishes.
d. I can make a decision to withhold or withdraw treatment which would allow the patient to die only if he or she has expressed clearly that I am permitted to make such a decision, and the patient understands that such a decision could or would allow his or her death.
e. I may not receive payment for serving as Patient Advocate, but I can be reimbursed for actual and necessary expenses which I incur in fulfilling my responsibilities.
f. I am required to act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.
g. The patient may revoke his or her appointment of me as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.
h. The patient may waive the right to revoke a designation as to the power to exercise mental health treatment decisions, and if such waiver is made, the patient's ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.
i. I may revoke my acceptance of my role as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.
j. A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Michigan Public Health Code, (Exercise of Rights by Patient's Representative 1978 PA 368, MCL 333.20201

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Accepting the Role of Patient Advocate (continued)

Patient Advocate Signature and Contact Information

I,_____, am assigning the Patient Advocate(s) listed below:

Print your name above and your Date of Birth here: _____

My Patient Advocate(s) will serve in the order listed below:

Patient Advocate

I,_____ have agreed to be the Patient Advocate for the person named above.
(PRINT)

Signature:_____ Date:_____

Address:_____

City/State/Zip: _____

Telephone: Primary (Cell☐)_____ Secondary (Cell☐) _____

First Alternate (Successor) Patient Advocate (Optional)

I,_____ have agreed to be the Patient Advocate for the person named above.
(PRINT)

Signature:_____ Date:_____

Address: _____

City/State/Zip:_____

Telephone: Primary (Cell☐)_____ Secondary (Cell☐) _____

Second Alternate (Successor) Patient Advocate (Optional)

I,_____ have agreed to be the Patient Advocate for the person named above.
(PRINT)

Signature:_____ Date:_____

Address: _____

City/State/Zip:_____

Telephone: Primary (Cell☐)_____ Secondary (Cell☐) _____

Making Changes

If only the contact information for your advocate(s) changes, it may be revised on the original and on the photocopies without replacing the entire form.

Photocopies of this form are acceptable as originals.

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Preferences for Spiritual/Religious & End of Life Care

(This section is optional, but recommended)

Spiritual/Religious Preferences

I am of the _____ faith/belief.

I am affiliated with the following faith/belief group/congregation:

_____.

Please attempt to notify my personal clergy or spiritual support person(s) at:

_____.

I want my health care providers to know these things about my religion or spirituality that may affect my physical, emotional or spiritual care: (*e.g., spiritual/religious rituals or sacraments, etc.)*

_____

_____

_____

____ ***I choose not to complete this section.***

At the End of my Life...

If possible, at the end of life, I would prefer to be cared for: either check or rank order all that apply:

____ in my home
____ in a hospital
____ in a long-term care facility
____ as my Patient Advocate thinks best

____ I would like hospice services in any of the above settings or in a hospice residence

In my last days or hours, if possible, I wish the following for my comfort: (*e.g., pain medication, certain music, readings, visitors, lighting, foods, therapy animal, etc.)*

_____

_____

_____

____ ***I choose not to complete this section.***

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Preferences for Anatomical Gift(s) – Organ/Tissue/Body Donation, & Autopsy

(This section is optional, but recommended)

In this section, you may, if you wish, state your instructions for: organ/tissue donation, autopsy, and anatomical gift.

The authority granted by me to my Patient Advocate regarding organ/tissue donation shall, in compliance with Michigan law, remain in effect and be honored following my death. I understand that whole-body anatomical gift donation generally requires pre-planning and pre-acceptance by the receiving institution.

Instructions:

• *Put your initials (or "X") next to the choice you prefer for each situation below.*

Anatomical Gift(s) – Donation of my Organs/Tissue/Body

____ I am registered on the Michigan Donor Registry and/or Michigan driver's license.
By Michigan law, your Patient Advocate and your family must honor your organ donation instructions.

Choose one option:

____ I am not registered, but authorize my Patient Advocate to donate any parts of my body that may be helpful to others {e.g., ORGANS [heart, lungs, kidneys, liver, pancreas, intestines], or TISSUES [heart valve, bone, arteries & veins, corneas, ligaments & tendons, fascia (connective tissue), skin]}

____ I am not registered, but authorize my Patient Advocate to donate any parts of my body, *EXCEPT* (name the specific organs or tissues):

_____

_____

____I ***do not want*** to donate any organ or tissue.

____I have arranged, or plan to arrange, donating my body to an institution of medical science for research or training purposes (*must be arranged in advance*).

____***I choose not to complete this section.***

(continues nextpage)

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Preferences for Anatomical Gift(s) – Organ/Tissue/Body Donation, & Autopsy

(This section is optional, but recommended)

Instructions:

- *Put your initials (or "X") next to the choice you prefer for each situation below.*
- *NOTE: A medical examiner may legally require an autopsy to determine cause of death. Other autopsies may be elected by next of kin (possibly at family expense).*

Autopsy Preference

_____ I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future health care decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

_____ If optional, I do not want an autopsy performed on me.

_____ ***I choose not to complete this section.***

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Preferences for Mental Health Examination & Treatment

(Optional)

☐ A determination of my inability to make decisions or provide informed consent for mental health treatment will be made by

_____.

(Physician/Psychiatrist)

_____ ***I choose not to complete this section***

I expressly authorize my Patient Advocate to make decisions concerning the following treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care

(initial one or more choices that match your wishes)

_____ outpatient therapy

_____ voluntary admission to a hospital to receive inpatient mental health services.
I have the right to give three days' notice of my intent to leave the hospital

*_____ Involuntary admission to a hospital to receive inpatient mental health services

*_____ psychotropic medication

*_____ electro-convulsive therapy (ECT)

*_____ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days' notice of my intent to leave a hospital if I am a formal voluntary patient.

***Choices with an asterisk require your express permission to your Patient Advocate(s) prior to treatment/action.**

I have specific wishes about mental health treatment, such as a preferred mental health professional, hospital or medication. My wishes are as follows:

_____

_____

_____

_____

_____ _____

(Sign your name if you wish to give your Patient Advocate this authority) Date

_____ ***I choose not to complete this section***

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Treatment Preferences (Goals of Care)

(This section is optional, but recommended)

Print Name:_____ Date of Birth: _____

Specific Instructions to my Patient Advocate

When I am not able to decide or speak for myself, the following are my specific preferences and values concerning my health care:

Instructions:

- *Put your initials (or "X") next to the choice you prefer for each situation below.*

Treatments to Prolong my Life

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, where I am, and I am unable to meaningfully interact with others:

____I want all possible efforts to prolong life made on my behalf, even if it means I may remain on life-sustaining equipment, such as a breathing machine or kidney dialysis, for the rest of my life.

OR

____I want my health care providers to try treatments to prolong my life for a period of time. If these treatments are not helping me get better, are not going to improve my current condition, or if they are causing me pain and suffering, then I want to stop these treatments.

OR

____I do not want to start treatments to prolong my life; if treatments have begun, please stop.

Medications and treatment intended to provide comfort or pain relief shall not be withheld or withdrawn.

____***I choose not to complete this section.***

____***Refer to my additional documents regarding my treatment preferences.***

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Cardiopulmonary Resuscitation (CPR)

(General Feelings/Preferences)

This is NOT a "Do Not Resuscitate" (DNR) Medical Order.
A DNR medical order is a separate legal document.

CPR is an attempt to restart your heart and breathing. It could include pressing hard on your chest to try to restart your heart and placing a tube into your windpipe to connect to the breathing machine. Electric shock to your heart and medications to support your heart may be included.

Instructions:

- Initial of place an "X" next to your choice

If my heart and breathing stops:

____ I **want** the healthcare team to try CPR in all cases.

OR

____ I **want** CPR unless my health care providers determine that I have any of the following:

- An injury or illness that cannot be cured and I am dying.
- No reasonable chance of surviving the CPR attempt.
- Little chance of surviving long term, and it would be hard and painful for me to recover from CPR.

OR

____ I ***do not want*** CPR but instead want to allow natural death.

____***I choose not to complete this section.***

Additional Specific Instructions

I want my Patient Advocate to follow these specific instructions, which may limit the authority previously described in General Instructions to My Patient Advocate.

_____

_____

____***I choose not to complete this section.***

Signature

If you are satisfied with your choice of Patient Advocate and with the Treatment Preferences guidance you have provided in this section, you need to sign and date the statement below.

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind. These are my preferences and goals expressed and affirmed on the date below:

Signature:_____ Date: _____

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