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Healthcare Planning Coalition

Advance Directive

Durable Power of Attorney for Healthcare
(Patient Advocate Designation)

Introduction

This document provides a way for an individual 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** allows you to appoint a person (and alternates) to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate**. This document gives your Patient Advocate authority to make your decisions *only when you have been determined unable to make your own decisions by two physicians, or a physician and a licensed psychologist*.

It *does not* give your Patient Advocate any authority 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.** If you do not closely involve your Patient Advocate, and you do not make a clear plan together, your views and values may not be fully respected 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 (Day): _____ (Evening): _____ (Cell): _____

Address: _____

City/State/Zip: _____

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

Advance Directive: My Patient Advocate

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my Patient Advocate. This person will make my health care decisions when I am determined, by either two physicians or a physician and licensed psychologist, to be incapable of making health care decisions. I understand that it is important to have ongoing discussions with my Patient Advocate about my health and health care choices. I hereby give my Patient Advocate permission to send a copy of this document to other doctors, hospitals and health care providers that provide my medical care.
(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 (if any):_____

Telephone (Day): _____ (Evening): _____(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 (if any):_____

Telephone (Day): _____ (Evening): _____(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 (if any):_____

Telephone (Day): _____ (Evening): _____(Cell): _____

Address: _____

City/State/Zip Code: _____

Advance Directive Signature Page

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 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 expressly authorize my Patient Advocate 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.

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

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:

Signature: _____ Date: _____

Print Name: _____

Address: _____

City/State/Zip Code: _____

Witness Number 2:

Signature: _____ Date: _____

Print Name: _____

Address: _____

City/State/Zip Code: _____

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)**, **Overview** 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

Accepting the Role of Patient Advocate *(continued)*
Patient Advocate Signature and Contact Information

Person completing Advance Directive:

Print Name: _____ Date of Birth:_____

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: _____

Phone (Day): _____(Evening): _____(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: _____

Phone (Day): _____(Evening): _____(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: _____

Phone (Day): _____(Evening): _____(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.

PREFERENCES FOR SPIRITUAL/RELIGIOUS AND END OF LIFE CARE

(THIS SECTION IS OPTIONAL, BUT RECOMMENDED)

SPIRITUAL/RELIGIOUS PREFERENCES

☐ My religious beliefs prohibit me from having an examination by a doctor, licensed pyschologist or other medical professional.

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:

___ 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., certain music, readings, visitors, lighting, foods, therapy animal, etc.)

_____

_____

_____

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

PREFERENCES FOR ANATOMICAL GIFT(S)–ORGAN/TISSUE/BODY DONATION, AUTOPSY, AND BURIAL/CREMATION

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

By Michigan law, your Patient Advocate and your family must honor your instructions pertaining to organ donation following your death.

The authority granted by me to my Patient Advocate in regard to 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. Burial or cremation preferences reflect my current values and wishes.

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.

____ 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 valves, bone, arteries & veins, corneas, ligaments and 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 ***want*** to donate 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 on next page)

PREFERENCES FOR ANATOMICAL GIFT(S)–ORGAN/TISSUE/BODY DONATION, AUTOPSY, AND BURIAL/CREMATION

(Continued)

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 (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.***

BURIAL/CREMATION PREFERENCE

My burial or cremation preference is: (initial only one)

____ Burial ____ Cremation ____ Green Burial

____ Burial or Cremation, at the discretion of my next-of-kin

____ I have appointed a Funeral Representative *(requires a separate legal document)*

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

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

____ 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.

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.***

Overview: Advance Care Planning is a process

As an adult with the ability to *make your own medical decisions*, you can accept, refuse, or stop medical treatment. If you lose the ability to make your own medical decisions (for instance, because of an accident or sudden illness), someone else will have to make those decisions for you. You can choose the person you want to make those decisions – called your "Patient Advocate" – and give that person information about your preferences, values, beliefs, wishes and goals that will help him or her make the decisions you would want.

You should thoughtfully identify your personal values, beliefs, wishes, and treatment goals regarding end of life care. With those values and beliefs in mind, you should then choose your Patient Advocate. Your Patient Advocate needs to learn your treatment goals and values, and be willing to act on your behalf, if and when necessary.

In Michigan, two physicians – or your attending physician and a licensed psychologist – have to examine you and declare that you lack the decision-making ability (also called decision-making capacity) before a Patient Advocate may act on your behalf.

It is also important for you and your Patient Advocate to know that by Michigan law:

- While you may appoint a Patient Advocate and alternate Patient Advocate(s), only one person may act as your Patient Advocate at any given time.
- Your Patient Advocate(s) must sign the form entitled "Accepting the Role of Patient Advocate" (or a similar form) before acting on your behalf.
- Your Patient Advocate may make a decision to refuse or stop life-sustaining treatment only if you have clearly expressed that he or she is permitted to do so.

NOTE: This Advance Directive will replace any Advance Directive you have completed in the past. You may change your mind about your Patient Advocate designation at any time by communicating in any manner that this designation does not reflect your wishes. A written, signed document is recommended, but not required.

PLEASE NOTE:

- *Your Patient Advocate may be a spouse or relative, but it is not required. For some people, a friend, partner, clergy or co-worker might be the right choice.*
- *Your Patient Advocate must be at least 18 years of age.*
- *He or she should be someone with whom you feel comfortable discussing your preferences, values, wishes and goals for future medical decision-making.*
- *He or she needs to be willing to follow those preferences even if that is difficult or stressful, and even if the decisions you would want made are different from the ones he or she would make for his or her own medical care.*
- *Your Patient Advocate must be willing to accept the significant responsibility that comes with this role.*

In summary, a good Patient Advocate must be able to serve as your voice and honor your wishes.

Instructing Your Patient Advocate

It is important for you to educate and inform your Patient Advocate about your preferences, values, wishes, and goals. You can give general instructions, specific instructions, or a combination of both.

It is also important for your Patient Advocate to know any particular concerns you have about medical treatment, especially any treatment you would refuse or want stopped. It is important to understand that under Michigan law, *your Patient Advocate can only make a decision to refuse or stop life-sustaining treatment if you have clearly given him or her specific permission to make that decision (see: Specific Instructions to My Patient Advocate).*

In order to serve you well, and to be able to make the medical decisions you would want made, your Patient Advocate needs to know a great deal about you. The discussions between you and the person you choose to be your Patient Advocate will be unique, just as your preferences, values, wishes, goals, medical history and personal experiences are unique.

Among the topics you might want to discuss with your Patient Advocate are:

- Experiences you have had in the past with family or loved ones who were ill;
- Spiritual and religious beliefs, especially those that concern illness and dying;
- Fears or concerns you have about illness, disability or death;
- What gives your life meaning or sustains you when you face serious challenges.

If your Patient Advocate does not know what you would want in a given circumstance, it is his or her duty to decide, in consultation with your medical team, what is in your best interest.

Your Patient Advocate will have your permission to:

- Make choices for you about your medical care or services, such as testing, medications, surgery, and hospitalization. If treatment has been started, he or she can keep it going or have it stopped depending upon your specific instructions;
- Interpret any instructions you have given in this form (or in other discussions) according to his or her understanding of your wishes and values;
- Review and release your medical records, mental health records, and personal files as needed for your medical care;
- Arrange for your medical care, treatment and hospitalization in Michigan or any other state, as he or she thinks appropriate or necessary to follow the instructions and directives you have given for your care.

What Now?

Now that you have completed your Advance Directive, you should also take the following steps:

- Tell the person you named as your Patient Advocate, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future. Have your Patient Advocate sign the Patient Advocate form ***as soon as possible!***
- Talk to the rest of your family and/or close friends who might be involved if you have a serious illness or injury. Make sure they know your wishes and the names of your Patient Advocate(s).
- Make sure your wishes are understood and will be followed by your doctor or other health care providers.
- Keep a copy of your Advance Directive where it can be easily found (do NOT place it in a safe deposit box!).
- If you go to a hospital or a nursing home, take a copy of your Advance Directive with you and ask that it be placed in your medical record.

Review your Advance Directive every time you have an annual physical exam or whenever one of the "Five D's" occur:

Decade – when you start each new decade of your life.
Death – whenever you experience the death of a loved one.
Divorce – if you (or your Patient Advocate) experience a divorce or other major family change.
Diagnosis – if you are diagnosed with a serious health condition.
Decline – if you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

Upon your request, a copy will also be sent to any other physician or healthcare facility providing care to you. *Photocopies of an Advance Directive may be relied upon as though they were originals.*

Who holds a copy of this Advance Directive?

Healthcare Providers:

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

Hospital System Medical Records Department:

Name: _____

Others (e.g. family members, friends, clergy, attorney):

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

I have authorized my Advance Directive to be registered with

❑ *Great Lakes Health Connect* ❑ _____

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. However, I want to stop these treatments if they do not help, or if they cause me pain and suffering.

OR

____ I want to stop or withhold all treatments to prolong my life.

In all situations, I want to receive treatment and care to keep me comfortable.

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

(continues on next page)

Instructions:

- *Put your initials (or "X") next to the choice you prefer for each situation below.*
- *NOTE: This is NOT a "Do Not Resuscitate" (DNR) Order, which is a separate legal document. Talk with your personal healthcare provider if you would like a DNR Order.*

CARDIOPULMONARY RESUSCITATION (CPR)

If my heart or breathing stops:

____ I **want** 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.
- 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.

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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Wallet Card

NOTICE: I have an Advance Directive

Name:_____

My Patient Advocate: _____

My Patient Advocate's phone number: _____

A copy of my Advance Directive can be found at:

_____

Specific instructions:_____

_____

_____

My physician's name:_____

My physician's phone number: _____

Signature/Date:

NOTICE: I have an Advance Directive

Name:_____

My Patient Advocate: _____

My Patient Advocate's phone number: _____

A copy of my Advance Directive can be found at:

_____

Specific instructions:_____

_____

_____

My physician's name:_____

My physician's phone number: _____

Signature/Date:

*This **Wallet Card** template is the same size as a credit card.*
Fill in your information, then photocopy this page, fold two-sided and tape or glue.