
# 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**, **Overview** and this completed **Patient Advocate Designation Form**, (including any optional **Preferences**). Also, take note of any **Treatment Preferences** (Goals of Care, 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***

# 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 psychologist 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 long-term care facility
___ in a hospital ___ 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.*

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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 in-formed 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.***

# 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 including intubation, advanced invasive airway interventions, cardioversion or kidney dialysis for the rest of my life.

*Transfer to hospital if indicated, includes intensive care.*

**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.

*Transfer to hospital if indicated, avoid intensive care.*

**OR**

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

*Only transfer to hospital if comfort needs cannot be met in current location.*

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

**Artificially Administered Nutrition: Always offer food by mouth if feasible.**

___ Long-term artificial nutrition

___ Defined trial period of artificial nutrition

___ No artificial Nutrition

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

**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: