

Designation of Patient Advocate Form



Designation of Patient Advocate Form and Directions for Healthcare (Durable Power of Attorney for Healthcare)

For:

Name: _____

Date of Birth: _____

This is an important legal document.
If you have any questions, you may
want to discuss them with your
doctor, attorney, or a certified
advance care planning facilitator.



AMD/DPOA - Healthcare

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and Honoring Healthcare Choices Michigan.*

Your Advance Care Planning Document

This is a legal document, also known as a “Durable Power of Attorney for Healthcare,” that allows you to:

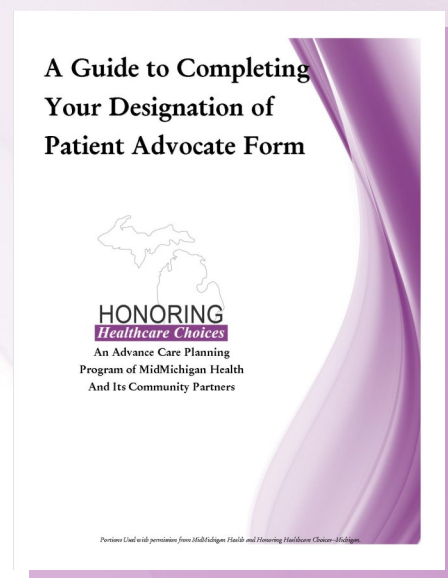
- Designate your Patient Advocate
- Define your future healthcare wishes should you ever be unable to speak for yourself in the event of an illness or injury

A coordinating workbook is available that can help you explore your values and feelings regarding your future healthcare wishes and end-of-life care options mentioned in this document. **The workbook also contains specific instructions designed to assist you in completing the Designation of Patient Advocate Form**, as well as a glossary of definitions related to future healthcare wishes and end-of-life planning.

If you would like a copy of the coordinating workbook, or if you need assistance completing this document, please contact MidMichigan Health’s Advance Care Planning Department at **(989) 839-3167**.

Please keep in mind:

- You do not have to complete this document
- This document will not go into effect unless two physicians, or one physician and one licensed psychologist, determine in writing that you are no longer able to make your own medical decisions
- You *always* have the right to change or revoke any details in this document



On this page, you will name someone to act for you regarding your care, custody and treatment if you would become unable to make decisions on your own behalf. This person is called a "Patient Advocate." You may name anyone who is at least eighteen years old and of sound mind. You should name one or more additional persons to act if your first choice cannot. *You should be sure that this person will honor your wishes, even if they disagree with them.* This person cannot act as your spokesperson unless they have signed the Patient Advocate Acceptance Form on page 11; and two physicians, or one physician and one licensed psychologist have determined, in writing, that you are unable to make your own medical decisions. Remember, you *always* have the right to revoke your Patient Advocate.

To my Family, Doctors and All Concerned With My Care:

These instructions express my wishes about my healthcare. I want my family, doctors and everyone else concerned with my care to act in accordance with them.

Appointment of Patient Advocate

I appoint the following person my Patient Advocate:

Patient Advocate's Name _____

Address _____

Telephone (h) _____ (w) _____ (c) _____

Appointment of Successor Patient Advocate(s)

I appoint the following person(s), in the order listed, my successor Patient Advocate if my Patient Advocate does not accept my appointment, is incapacitated, resigns, is removed or I am divorced or separated from him/her after the date signed on this form. My successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

Successor Patient Advocate's Name _____

Address _____

Telephone (h) _____ (w) _____ (c) _____

Successor Patient Advocate's Name _____

Address _____

Telephone (h) _____ (w) _____ (c) _____

My Patient Advocate or successor Patient Advocate may delegate his/her powers to the next successor Patient Advocate if he or she is unable or unwilling to act.

My Patient Advocate or successor Patient Advocate may only act if I am unable to participate in making decisions regarding my medical or, as applicable, mental health treatment.

This section gives instructions for your care. Cross out and initial any instructions you do not want.

Under instruction 1.b., your Patient Advocate has the right to make arrangements for your care but is not personally responsible for the cost of your care.

Note: Current law does not permit your Patient Advocate to make decisions to withhold or withdraw treatment if you are pregnant, if that decision would result in your death; to engage in homicide or euthanasia; or to force medical treatment you do not want because of your religious beliefs. You may also list specific care and treatment you do or do not want. Otherwise, your general instructions will stand for your wishes.

Instructions For Care

1. General Instructions

My Patient Advocate shall have the authority to make all decisions and to take all actions regarding my care, transfer of care, custody, and mental health treatment including, but not limited to the following:

- a. Have access to, obtain copies of and authorize release of my medical, mental health and other personal information.
- b. Hire and discharge physicians, nurses, therapists, any other healthcare providers, mental health professionals and other providers, and arrange to pay them reasonable compensation.
- c. Consent to, refuse or withdraw on my behalf any medical or mental health care; diagnostic, surgical or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments. I understand that life-sustaining treatment includes, but is not limited to, breathing with the use of a machine and receiving food, water and other liquids through tubes. I also understand that these decisions could or would allow me to die. I have listed below and on the following pages any specific instructions I have related to life-sustaining treatments.

2. Specific Instructions

My Patient Advocate is to be guided in making medical and mental health decisions for me by what I have told him/her about my personal preferences regarding my care. Some of my preferences are record-ed on the following pages.

Page 5 lists choices concerning your general wishes regarding life-sustaining treatment, as well as an option to list types of care that you specifically do or do not want. **Pages 6-8** contain a list of many future healthcare and end-of-life topics that you may choose to address in this document.

If you are not familiar with any of the terms on the following pages, **please consult the coordinating workbook** for a complete list of definitions and sample language you may want to use in this portion of your Designation of Patient Advocate Form. If you do not have a workbook and would like one, please call MidMichigan Health at (989) 839-3000 and ask for the advance care planning department.

a. Specific Instructions Regarding Medical Examinations

My religious beliefs prohibit a medical examination to determine whether I am unable to participate in making medical treatment decisions. I desire this determination to be made in the following manner:

This portion of your Designation of Patient Advocate Form addresses important choices regarding life-sustaining treatment. You do not have to choose one of the four specific instructions about life sustaining treatment in this section, but if you do, **sign only one instruction.** You should discuss these choices with your doctor if you have any questions.

b. Specific Instructions Regarding Life-Sustaining Treatment

I understand that I do not have to choose one of the instructions regarding life-sustaining treatment listed below. If I choose one, I will sign below my choice.

Regardless of whether I sign one of the choices listed below, I direct that reasonable measures be taken to keep me comfortable and relieve pain.

Choice 1: Regardless of my condition, I do not want life-sustaining treatment initiated.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here: _____

Choice 2: If I have an end-stage illness or irreversible condition, I do not want life-sustaining treatment initiated.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here: _____

Choice 3: If I have an end-stage illness or irreversible condition, I want my life to be prolonged by life-sustaining treatment until it is determined by my physician that medical intervention is futile. At that time, I want all life-sustaining treatment discontinued.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here: _____

Choice 4: I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition, the chances I have for recovery, or the cost of my care, and I direct life-sustaining treatment be provided in order to prolong my life.

If this statement reflects your desires, sign here: _____

c. Additional Specific Instructions Regarding Care That I DO or DO NOT Want:

Optional Provisions

The following designation, authorizations, and waiver are **optional**. If you choose to affirm any of the options, please check the corresponding box and sign where indicated.

- Specific Instructions Regarding Organ and Tissue Donation: My Patient Advocate has the authority, upon or immediately before my death, to make an anatomical gift of all or a part of my body for therapy or transplantation needed by another individual; for medical or dental education, research or the advancement of medical or dental science; or for any other purpose permitted by law. This authority granted to my Patient Advocate shall remain exercisable following my death.

- I wish to designate a particular physician and/or mental health practitioner to examine me and make the determination as to my ability to participate in medical treatment decisions.

The individual I wish to designate is: _____
Name of Physician(s) and/or Mental Health Practitioner(s)

- I authorize my Patient Advocate to consent to inpatient hospitalization related to mental health treatment. I authorize my Patient Advocate to consent to the forced administration of medication related to mental health treatment.

- I waive my right to immediately revoke my Patient Advocate designation as to mental health treatment decisions. By waiving this right, I understand that any future attempt to revoke my Patient Advocate designation as to mental health treatment decisions will be delayed for 30 days.

Date: _____ Signature: _____

This document is to be treated as a Durable Power of Attorney for Healthcare and shall survive my disability or incapacity. If I am unable to participate in making decisions for my care and there is no Patient Advocate or successor Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and that this document be treated as conclusive evidence of my wishes. It is also my intent that anyone participating in my medical treatment shall not be liable for following the directions of my Patient Advocate that are consistent with my instructions.

The following are my personal preferences that may or may not be appropriate, or possible, given the unknown circumstances I may face in the future. I ask that these preferences be considered and honored when possible, reasonable, and medically and financially appropriate. I authorize my Patient Advocate to make final decisions in these matters when dealing with future circumstances in which these preferences become relevant.

You do not have to write anything on this page, but if you have preferences regarding any of these topics, please use the space below to express them.

Preferences Regarding Palliative Care (Symptom Management):

Preferences Regarding Long Term Care and Housing:

Preferences Regarding Artificial Nutrition or Tube Feeding:

Preferences Regarding Hospice:

You do not have to write anything on this page, but if you have preferences regarding any of these topics, please use the space below to express them.

Regarding My Views on Life:

Regarding Special Preferences:

Regarding Final Thoughts and Hopes:

Other Things I Want My Patient Advocate to Know:

(Please continue on page 12, if more space is needed.)

Sign and date below in the presence of at least two witnesses who meet the following requirements:

The individuals ARE:

- At least 18 years of age
- Of sound mind

The individuals ARE NOT:

- Your husband or wife, parent, child, grandchild, grandparent, brother or sister
- Your presumptive heir
- A known beneficiary of your will at the time of witnessing
- Your physician
- A person named as your Patient Advocate
- An employee of your life or health insurance provider
- An employee of a health facility that is treating you
- An employee of a home for the aged where you reside

This document is signed in the State of Michigan. I intend that it be applied to the fullest extent possible wherever I may be. Photocopies of this document can be relied upon as though they were originals.

My signature represents my intent to expressly revoke any and all previous patient-advocate designations. The instructions for care in this document represent my current treatment decisions. Any document or statement that is inconsistent with this document is expressly revoked. I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn. I am at least eighteen years old and of sound mind.

Signature

Sign Name _____ Date _____

Name _____

Address _____

Witness Statement And Signatures

If the witness does not personally know the person who is signing this Designation, the witness should ask for identification, such as a driver's license.

I declare that the person who signed this Designation of Patient Advocate signed it in my presence and is known to me. I also declare that the person who signed appears to be of sound mind and under no duress, fraud or undue influence and is not my husband or wife, parent, child, grandchild, grandparent, brother or sister. I declare that I am not the presumptive heir of the person who signed the previous page, the known beneficiary of his/her will at the time of witnessing, his/her physician or a person named as the Patient Advocate. I also declare that I am not an employee of a life or health insurance provider for the person who signed, an employee of a health facility that is treating him/her, or an employee of a home for the aged where he/she resides. I am at least eighteen years old and of sound mind.

Witnesses

Sign Name: _____

Sign Name: _____

Print Name: _____

Print Name: _____

Address: _____

Address: _____

Date signed: _____

Date signed: _____

You should discuss this document with the person(s) you want to have as your Patient Advocate(s) and have him/her sign the Acceptance of Patient Advocate on the following page:

Patient Advocate Designation Acceptance

I, _____, accept the designation of Patient Advocate for _____, and I agree to perform the duties given to me as Patient Advocate, subject to the terms, conditions and restrictions specified below.

- (a) **Effective.** This designation will not become effective unless the patient is unable to participate in medical or mental health treatment decisions.
- (b) **Limitations.** I will not exercise powers concerning the patient’s medical or mental health treatment that the patient, if able to participate in the decision, could not have exercised on patient’s own behalf.
- (c) **Pregnancy.** I will not make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant if it would result in the patient’s death.
- (d) **Withholding of Treatment.** I will not make a decision to withhold or withdraw treatment that would allow the patient to die unless the patient has clearly expressed that I am authorized to make such a decision, and that he or she understands such a decision could cause his or her death.
- (e) **Compensation.** I will not receive compensation for the performance of my responsibilities, but I may be reimbursed for expenses.
- (f) **Fiduciary Standards.** I will act consistent with the patient’s best interests. The desires of the patient expressed while able to participate in treatment decisions are presumed to be in the patient’s best interests.
- (g) **Revocation of Designation.** The patient may waive his or her right to revoke the designation immediately, at any time, by expressing his or her intent to revoke (except as provided under paragraph h below).
- (h) **Waiver.** The patient may waive the right to immediately revoke the designation as to mental health treatment. If the patient waives this right, any attempt by the patient to revoke his or her designation as to mental health will not be effective until a period of 30 days has passed.
- (i) **Revocation of Acceptance.** I may revoke this acceptance at any time by expressing my intent to revoke.
- (j) **Patient Rights.** A patient admitted to a health facility has the rights listed in Section 333.20201 of the Michigan Compiled Laws, as amended.
- (k) **Anatomical Gifts.** My authority to make a donation of bodily organs may be exercised after the patient’s death.

This is the continuation of the Patient Advocate Designation Acceptance portion of your document. **You must have your Patient Advocate(s) sign below in order for them to be able to act as your Patient Advocate.**

If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the persons the Patient has designated as successor Patient Advocate in the order designated. The successor Patient Advocate is authorized to act until I become available to act.

Patient Advocate

Print name: _____

Patient Advocate's Signature

Successor Patient Advocate

Print name: _____

Successor Patient Advocate's Signature

Successor Patient Advocate

Print name: _____

Successor Patient Advocate's Signature

Keeping Track of Your Advance Care Planning Document

Keep the signed original with your personal papers at home. **Please give a copy to your Patient Advocate(s), your physician, and the hospital where you are likely to receive treatment.** If you decide to update this document, please be sure to revoke all copies that you have distributed. You may do this by writing "revoked" across the document, or by disposing of the document. Once you have revoked a version of this document and created a new one, make sure that all parties who need a copy are given copies of your revised document. (Complete the following so that it will be easy to track your documents should you ever revise or replace your current document.) **This document must be copied in it's entirety, even if sections are left blank.**

I have given copies of my Designation of Patient Advocate Form to the following:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Things I Want My Patient Advocate to Know (Continued from page 8)

Please use this space for any special preferences you would like your Patient Advocate to know that you were unable to fit on page 8.

Reaffirming Your Designation of Patient Advocate Form

You should review this document from time to time to be certain that it still conveys your beliefs and desires for future healthcare. It's helpful to remember to reaffirm or change your Designation of Patient Advocate Form when experiencing any of "The Five D's." The Five D's are:

Divorce (A divorce could alter your choice of Patient Advocate even if your Advocate is someone other than your former spouse.)

Death (The death of your Patient Advocate must be addressed to ensure that there is someone to speak on your behalf if you become unable to speak for yourself. Also, experiencing a death of someone close to you, even if they were not your Advocate, may impact the decisions you've declared in this document.)

Diagnosis (If you or your Patient Advocate have received a new diagnosis, it may impact the desires and instructions you have listed in this document. It may also impair your Advocate's ability to speak on your behalf in the future.)

Decline (If you or your Patient Advocate have experienced a decline in health, it is a good idea to re-assess your wishes and roles moving forward. It is important that your Advocate have the ability to communicate your wishes if you become unable to speak for yourself.)

Decade (If you haven't re-read this document in 10 years, it is wise to review it and make sure that it still reflects your intentions.)

When you review this document, if it still expresses your intent, sign and date under the Reaffirmed section below to show that you still agree with its contents. If your wishes have changed, destroy or revoke this document as described on page 11, complete a new one, and give a copy to everyone who needs to have the new version.

REAFFIRMED

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Don't Be Confused

Based on a Michigan law passed in 1990, the "Designation of a Patient Advocate" is legally binding and is sometimes called a "Durable Power of Attorney for Healthcare."

Don't confuse the term "Durable Power of Attorney for Healthcare" with the term "Durable Power of Attorney," which relates to decisions about your financial matters.

The person named as your Patient Advocate in this document cannot make any decisions about your finances unless you choose that same person to make financial decisions on your behalf in a separate legal document. Likewise, your Durable Power of Attorney is not able to make decisions regarding your medical treatment unless they are also named as your Patient Advocate or your Durable Power of Attorney for Healthcare.

Speak with your attorney if you are uncertain about what arrangements you may already have in place should you face an illness or serious injury.

Your DURABLE POWER OF ATTORNEY FOR HEALTH CARE WALLET IDENTIFICATION CARD

The wallet card below is provided for the purpose of alerting emergency medical personnel to the existence of a Durable Power of Attorney for Healthcare (DPOAHC) in the event that you require medical treatment and are unable to verbally inform health care providers that a Patient Advocate has been appointed to act in your behalf. It is recommended that you complete the card by filling in the indicated names and telephone numbers and carry it with you at all times.

1. On the front of the card, print your full name in the space labeled "Patient's Name."
2. On the back of the card, print the names and telephone numbers of the persons you have appointed as your Patient Advocate and Successor Patient Advocate(s) in the spaces provided. (Make sure the names and telephone numbers are the same as those listed in your Designation Form.) Space is also provided on the card to write in the name and telephone number(s) of a third person who has a copy of your Designation Form. This may be the person you have named as your Second Successor Patient Advocate, or if you have not designated a Second Successor Patient Advocate, any other person to whom you have given a copy of your completed form.
3. Carefully cut out the card along the dashed lines and place it in an obvious place in your wallet or billfold. Be sure to update the information on the card if there is a change in the telephone number(s) of any of the people you have listed on it, or if you subsequently complete a new Designation of Patient Advocate Form in which different individuals are designated to act as your Patient Advocate and/or Successor Patient Advocate(s).

IMPORTANT NOTICE TO EMERGENCY MEDICAL PERSONNEL

I, _____,
(Patient's Name)
have executed a Durable Power of Attorney for Health Care pursuant to 1990 Public Act 312, MCL 700.496. If I am unable to make my own health care decisions, my Patient Advocate has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatment. In such an event, one of the persons listed on the reverse of this card who has a copy of my Durable Power of Attorney for Health Care should be contacted immediately, in the order listed. (See reverse.)



If you would like to obtain a workbook to help you better understand this document, or if you would like to schedule an advance care planning consultation to discuss or complete your Designation of Patient Advocate Form, please contact MidMichigan Health's Advance Care Planning Department at (989) 839-3167.



HONORING *Healthcare Choices*

An Advance Care Planning
Program of MidMichigan Health
and its Community Partners

1. Patient Advocate: _____

Work: _____ Home: _____

2. Successor Patient Advocate: _____

Work: _____ Home: _____

3. Other: _____

Work: _____ Home: _____

Organ Donor Yes _____ No _____

Do Resuscitate _____ Do Not Resuscitate _____

