

Designation of Patient Advocate Form

Advance Directive for Health Care

*Durable Power of Attorney
for Health Care*



NOTE:

On this page, name someone to act for you regarding your care, custody, and treatment.

This person is called a "Patient Advocate." You may name anyone who is at least eighteen years old and of sound mind.

You may also name one or more persons to act if your first choice cannot.

If you change your mind, you may revoke your appointment of a Patient Advocate at any time.

To my family, doctors, and all concerned with my care:

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

Appointment of Patient Advocate

I appoint the following person as my Patient Advocate:

Patient Advocate's name: _____

Address: _____

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, or is removed. My successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

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

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

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, custody, and medical treatment including, but not limited to, the following:

- a. Have access to, obtain copies of, and authorize release of my medical and other personal information.
- b. Employ and discharge physicians, nurses, therapists, and any other health care providers, and arrange to pay them reasonable compensation.
- c. Consent to, refuse, or withdraw from me any medical 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 any specific instructions I have related to life-sustaining treatments in the following section.

2) *Specific Instructions*

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

A. **Specific Instructions Regarding Life-Sustaining Treatment**

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

In addition, if I sign one of the choices listed, I direct that reasonable measures be taken to keep me comfortable and relieve pain.

NOTE:

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 required personally to pay the cost of your care.

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 list specific care and treatment you do or do not want. Otherwise your general instructions will stand for your wishes.

NOTE:

You do not have to choose one of the 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.

Choice 1: I do not want my life to be prolonged by providing continuing life-sustaining treatment if any of the following medical conditions exist.

- I am in an irreversible coma and persistent vegetative state.
- I am terminally ill and life-sustaining procedures would serve only to artificially delay my death.
- Under any circumstances where my medical condition is such that the burdens of the treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my Patient Advocate to consider the relief of suffering and the quality of my life as well as the extent of possibly prolonging my life.

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

If this statement reflects your desires, sign here: _____

Choice 2: I want my life to be prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued.

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

If this statement reflects your desires, sign here: _____

Choice 3: I want my life to be prolonged to the greatest extent possible consistent with sound medical practice.

If this statement reflects your desires, sign here: _____

B. Specific Instructions Regarding Care I Do Want

C. Specific Instructions Regarding Care I Do Not Want

D. 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 document is to be treated as a Durable Power of Attorney for Health Care 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.

This document is signed in the State of Michigan. It is my intent that the laws of the State of Michigan govern all questions regarding its validity, the interpretation of its provisions and its enforceability. I also 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.

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: _____

Print name: _____

Address: _____

NOTE:

Sign and date here in the presence of at least two witnesses who meet the requirements listed in the witness statement on the following page.

NOTE:

If the witness does not personally know the person who is signing this Designation, the witness should ask for positive identification.

Only two witnesses are required. Using three will protect the validity of the Designation if one witness is later found to be ineligible.

Keep the signed original with your personal papers. Give signed copies to your doctor, family, the medical facility where you are being treated and to Patient Advocates. Occasionally review this document, especially when there is a change in your health or family status. If it still expresses your intent, sign and date under Reaffirmed to show you still agree with its contents. If your wishes change, destroy this document, make out a new one and give a copy to everyone who has an old version.

Witness Statement and Signature

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, child, grandchild, 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, and that I am at least eighteen years old.

Witness:

Sign name: _____ Sign name: _____

Name: _____ Name: _____

Address: _____ Address: _____

Date: _____ Date: _____

Sign name: _____

Name: _____

Address: _____

Date: _____

Reaffirmed

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Acceptance of Patient Advocate

The patient Advocate and any successor Patient Advocate must sign this Acceptance before he/she may act as Patient Advocate.

I agree to be the Patient Advocate for _____
(called "Patient" in the rest of this document). I accept the Patient's designation of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the patient as indicated in the Designation of Patient Advocate, in other written instructions of the Patient, and as we have discussed verbally.

I also understand and agree that:

- a. This designation shall not become effective unless the Patient is unable to participate in medical treatment decisions.
- b. A Patient Advocate shall not exercise powers concerning the patient's care, custody, and medical 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. This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from an Patient who is pregnant that would result in the pregnant Patient's death.
- d. A Patient Advocate may make a decision to withhold or withdraw treatment which would allow a Patient to die only if the patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision, and that the Patient acknowledges that such a decision could or would allow the Patient's death.
- e. A Patient Advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibility.
- f. A Patient Advocate shall 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 interest. The known desires of the Patient expressed or evidenced while the Patient is able to participate in medical treatment decisions are presumed to be in the Patient's best interests.

continued next page

NOTE:

You should discuss this document with the person you want to have as your Patient Advocate and have him or her sign the Acceptance of Patient Advocate.

The restrictions listed here and on the following pages are required by the Patient Advocate Act of 1990. P.A. No. 321/(MCL.700.496)

The card below is explained on the next page.

1. Patient Advocate: _____
Work: () _____ Home: () _____

2. Successor Patient Advocate: _____
Work: () _____ Home: () _____

3. Successor Patient Advocate: _____
Work: () _____ Home: () _____

Organ donor? Yes _____ No _____
(see reverse side)

NOTE:

The wallet card below is provided for the purpose of alerting emergency medical personnel to the existence of your Patient Advocate.

Please print your name on the front of the card and print the names and telephone numbers of your Patient Advocate and Successor Patient Advocate on the reverse side. Then carefully tear off the card and place in an obvious place such as your wallet or billfold.

- g. A Patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
- h. A Patient Advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.
- i. A Patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

If I am unable 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

Sign name: _____

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Successor Patient Advocate

Sign name: _____

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Successor Patient Advocate

Sign name: _____

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

IMPORTANT NOTICE TO EMERGENCY MEDICAL PERSONNEL

I, _____ 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 decisions, my Patient Advocate has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatments. 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 of card.)