Your Health
Your Choice

MY ADVANCE DIRECTIVE

McLaren
MEDICAL GROUP

Introduction

This document expresses my preferences about my medical care if I cannot communicate my wishes or make my own health care decisions. I want my family, doctors, other healthcare providers, and anyone else concerned with my care to follow my wishes. For this reason, I give my patient advocate permission to share this document with doctors, hospitals, and health care providers that provide care to me. Likewise, health care providers with whom I have given this document may share it with other providers involved in my care. Any document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

My telephone number: _____ My cell: _____

Date document completed: _____

VERSION 10/17/13

MY CHOICE FOR MY PATIENT ADVOCATE

If I am unable to communicate my wishes and health care decisions due to illness or injury, or if my health care providers have determined that I am not able to make my own health care decisions, I choose the following person(s) to represent my wishes and make my health care decisions.* My patient advocate must follow my health care instructions in this document and any other instructions I have given to them and must make decisions that are in my best interest.

I, _____ choose the person named below to be my primary Patient Advocate:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

If I cancel my primary patient advocate's authority, or if my primary patient advocate is not willing, able, or reasonably available to make a health care decision for me, I name as my alternative patient advocate (in the order listed):

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

My Healthcare Instructions

General Instructions

When I am unable to speak for myself, I want my Patient Advocate to be able to:

- Make choices for me about my medical care or services, such as testing, medications, surgery, hospitalization, and hospice care. If treatment has been started, he or she can keep it going or have it stopped depending upon my specific instructions (see section on next page) or, if I have included no specific instructions, my best interest;

- Interpret any instructions I have given in this form (or in other discussions) according to his or her understanding of my wishes, values, and beliefs;

- Review and release my medical records and personal files as needed for my medical care;

- Participate in deciding arrangements for my medical care, treatment and hospitalization in Michigan or any other state, as he or she thinks appropriate;

- Determine which health professionals and organizations may provide my medical treatment.

Mental Health Advance Directive

Michigan law gives individuals the right to complete an advance directive for their mental health treatment. Please contact your local community mental health agency (Genesee Health System) to learn of your rights regarding a mental health advance directive and for assistance in preparing the document.

Specific Instructions for Life Sustaining Treatment (optional)

I give my patient advocate permission to make the following decisions regarding my preferences for my health care and request my health care providers honor them should I become unable to communicate or make my own choices. I understand that I can choose one of the three (3) instructions regarding life-sustaining treatment listed on the next page. If I choose one, I will sign my name below my choice. I understand I do not have to pick any of these choices if I do not wish to do so. With any choice, I understand that reasonable measures will be taken to keep me comfortable and free from pain as much as possible.

Life sustaining treatment is any medical device or procedure that increases your life expectancy by restoring or taking over a vital bodily function. This includes antibiotics and other medications, a breathing machine (ventilator), surgery, CPR, dialysis, and receiving food, water and other liquids through tubes.

You may <u>select only one choice.</u> 1) **Check the choice you wish, 2) sign your name below your choice and 3) cross out the choices you do not want. Specific instructions pertaining to your choice may be outlined on the following page.**

☐ **Choice #1**

I want to stop or withhold treatments that might be used to keep my body alive longer, if any of these conditions exist:

If it is reasonably certain that I will not recover my ability to interact meaningfully with my family, friends, and environment;

I am close to death;

I am terminally ill and these treatments would only artificially keep me alive longer;

I am in a coma and/or have severe, permanent brain damage and am not expected to recover;

The burdens of the medical treatment outweigh the benefits.

This Choice is my wish for treatment. I understand this decision could or would allow me to die.

If this Choice is your wish for treatment, 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 is irreversible. Once my doctor concludes I am permanently unconscious, I do not want life-sustaining treatment to be given or continued.

This Choice is my wish for treatment. I understand this decision could or would allow me to die.

If this Choice is your wish for treatment, sign here: _____

☐ **Choice #3**

I want my life to be prolonged as long as possible. I wish for life-sustaining treatments to be provided until my doctor and patient advocate agree that such treatments are harmful or no longer helpful.

This Choice is my wish for treatment.

If this Choice is your wish for treatment, sign here: _____

Other Specific Instructions

I want my patient advocate to follow the specific instructions I have written and signed below. These instructions may complement in further detail or limit the General and Specific Instructions described on the preceding page.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My Signature _____

Donation of My Organs or Tissue:
(Check one choice only and draw a line through the statements that you do not want.)

☐ I wish to donate any organs or tissue if possible.

☐ I wish to donate only the following organs or parts if possible (name the specific organs or tissue):

_____

☐ I do not want to donate any organ or tissue.

My Hopes and Wishes (Optional but Encouraged)

An individual's responses regarding their hopes and wishes have been shown to improve the patient advocate's ability to guide the healthcare decision making process.

I want my patient advocate and loved ones to know my following thoughts and feelings:

1. The things that make life most worth living to me are:

   _____

   _____

   _____

   _____

   _____

2. My beliefs about when life would be no longer worth living:

   _____

   _____

   _____

   _____

   _____

3. My choices about specific medical treatments, if any (this could include your wishes regarding ventilators, dialysis, antibiotics, tube feedings, etc.):

   _____

   _____

   _____

   _____

   _____

4. My thoughts and feelings about how and where I would like to die:

   _____

   _____

   _____

   _____

   _____

5. If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (Family members, pets, rituals, prayers, music, etc.):

_____

_____

_____

_____

_____

6. Religious affiliation:

   I am of the _____ faith, and am a member of

   _____ faith community in (city) _____.

   Please attempt to notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

_____

_____

_____

_____

_____

7. Other wishes/instructions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Making My Advance Directive Legal

Patient Signature

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: _____

Name (*Print or Type*): _____

Address: _____

_____

Witness Statement and Signature

I know this person to be the individual identified in the Patient Advocate 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 alternative appointed by the person signing this document.
- Not the spouse, parent, child, grandchild, brother or sister of the person signing this document.
- Not directly financially responsible for the person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee of a health care or insurance provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness Number 1:

Signature: _____ Date: _____

Name (*Print or Type*): _____

Address: _____

_____

Witness Number 2:

Signature: _____ Date: _____

Name (*Print or Type*): _____

Address: _____

_____

MY PATIENT ADVOCATE'S ACCEPTANCE

Patient Name: _____

Patient Date of Birth: _____

The person named above has asked you to serve as his or her Patient Advocate (or as an alternate or "back up" Patient Advocate).

Before agreeing to take on that responsibility and signing this form, please carefully read:

1. A copy of the form the person filled out entitled "My Choice for My Patient Advocate" and;
2. The document entitled "A Brief Guide to Advance Care Planning," which provides important information and instructions.

Most importantly, take the time to talk to the person choosing you as Patient Advocate so that you can gain the knowledge you need to allow you to make the decisions he or she would want made.

If you are willing to accept the role of Patient Advocate, please read and sign the following statement. Your signature does NOT need to be witnessed or notarized.

I accept the patient's selection 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 "My Choice for Patient Advocate" form (or in other written or spoken instructions from the patient).

I also understand and agree that:

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 understand 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 mental health 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 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, 1978 PA 368, MCL 333.20201

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

Patient Advocate

Signature: _____ Date: _____

Name (*Print or Type*): _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Alternative Patient Advocate

Signature: _____ Date: _____

Name (*Print or Type*): _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Alternative Patient Advocate

Signature: _____ Date: _____

Name (*Print or Type*): _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

NEXT STEPS

Now that you have completed your health care directive, you should also take the following steps.

- Give your patient advocate a copy of your health care directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your patient advocate is, and what your wishes are.
- Give a copy of your health care directive to your doctors. Make sure your wishes are understood and will be followed.
- Keep a copy of your health care directive where it can be easily found and accessed.
- If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any 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 – when you experience a divorce or other major family change.
  Diagnosis – when you are diagnosed with a serious health condition.
  Decline – when you experience a significant decline or deterioration of an existing health condition especially when you are unable to live on your own.

A copy of your advance directive will be provided to Michigan Health Connect as an electronic record. Genesee County health providers, who are subject to strict privacy laws under HIPAA, may access these records only if they have a valid medical reason pertaining to your treatment. If you do not want your advance directive stored with Michigan Health Connect you may opt out by obtaining a form from their website at www.michiganhealthconnect.org or phoning them at 877-269-7860.

Copies of this document have been given to:

Primary Patient Advocate Name: _____

Alternative Patient Advocate Name: _____

Alternative Patient Advocate Name: _____

Health Care Provider/Clinic

Name: _____ Telephone: _____

Name: _____ Telephone: _____

If your wishes change, fill out a new health care directive form and tell your agent, your family, your doctor, and everyone who has copies of your old health care directive forms.