

DESIGNATION OF PATIENT ADVOCATE FORM

Michigan's form of Advance Directives/Durable Power of
Attorney for Healthcare

AND DIRECTIONS FOR HEALTHCARE

This is an important legal document that has to be signed, dated and witnessed. You should discuss it with your doctor and attorney if you have questions.



BAY REGION

mclaren.org/bayregion



DO I HAVE TO APPOINT A PATIENT ADVOCATE?

You have the option to appoint a Patient Advocate but cannot be required to do so. Health and life insurers cannot discriminate against individuals who complete or do not complete a Designation Form. In addition, physicians and other health care providers cannot require you to appoint a Patient Advocate as a precondition to providing health care services.

But, the advantage is to insure your choice is available to make the medical and/or mental health treatment decisions, including withholding or withdrawing treatments, that you would when you are unable to do so.

Families sometimes find it difficult to withhold or stop treatment even when they know the patients' wishes, or families are unable to come to a consensus. These situations can lead to lengthy and sometimes costly guardianship proceedings. In the interim, the physician may need to initiate aggressive treatment, including placing a patient on a ventilator and starting tube feedings.

Before McLaren-Bay Region can accept your designation form, it must be reviewed to ensure it has been prepared and meets criteria set forth by the Michigan legislature. The form in this booklet complies.

NOTE: It is generally recommended to complete this documentation before you are admitted to the hospital or in a potential "medical crisis" situation.

*Reminder: Hospital employees are prohibited from acting as witnesses by the Michigan legislature.

DESIGNATION OF PATIENT ADVOCATE FORM

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.

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 and/or mental health 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. **Your patient advocate has the right to make arrangements for your care, but is not required to personally pay for the cost of your care.**
- c. Consent to refuse or withdraw for 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 below any specific instructions I have related to life-sustaining treatments.

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 and/or mental health treatment you do not want because of your religious beliefs.

PATIENT ADVOCATE

Sign Name _____

Name (Type or Print) _____

Address _____

Home Phone _____ Work Phone _____

Successor PATIENT ADVOCATE

Sign Name _____

Name (Type or Print) _____

Address _____

Home Phone _____ Work Phone _____

Successor PATIENT ADVOCATE

Sign Name _____

Name (Type or Print) _____

Address _____

Home Phone _____ Work Phone _____

5. 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 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 or give informed consent to mental health treatment.
- b. A Patient Advocate shall not exercise powers concerning the patient's care, custody, and medical and/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. This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a 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 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, right and responsibilities.
- 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 interests. The known desires of the Patient expressed or evidenced while the Patient is able to participate in medical and/or mental health treatment decisions are presumed to be in the Patient's best interest.
- g. A Patient may revoke his or her designation at any time and in any manner sufficient to communicate intent to revoke.
- h. A patient may waive his or her right to revoke the designation as to the power to make mental health treatment decisions and, if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for up to 30 days.
- i. A Patient Advocate may revoke his or her acceptance to the designation at any time and any manner sufficient to communicate intent to revoke.
- j. 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.
- k. If the designation authorizes the Patient Advocate to make an anatomical gift, the authority remains exercisable after the Patient's death. A Patient Advocate may not exercise the authority to make an anatomical gift if the Patient Advocate has received actual notice that the Patient expressed an unwillingness to make the gift.

2. Specific Instructions

My patient Advocate is to be guided in making medical and/or mental health decisions for me by what I have told him/her about my personal preferences regarding life-sustaining treatment.

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

- I am in an irreversible coma or 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 decisions, sign here: _____

Choice 3: I want my life 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 decisions, sign here: _____

Choice 4: My preferences that are not covered in the above choices:

Choice 5:

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, or give informed consent to mental health treatment. I desire this determination to be made in the following manner:

3. Specific Instructions Regarding Anatomical Gifts (Optional)

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.

If this statement reflects your desires, sign here:

Patient's Signature _____

4. Specific Instructions Regarding Mental Health Treatment

I understand that I may, but am not required, to designate a physician, mental health practitioner, or both, to certify, in writing and after examining me, that I am unable to give informed consent to mental health treatment. If any physician or mental health practitioner whom I designate is unable or unwilling to conduct the examination and to make this determination within a reasonable time, I understand that another physician or mental health practitioner, as applicable, shall make the examination and determination.

I designate the following physician(s) and/or mental health practitioner(s) for this purpose
(no designation is made if left blank):

Name of Physician(s) and/or Mental Health Practitioner(s)

With regard to mental health treatment decisions, my Patient Advocate is authorized to consent to the forced administration of medication, or to inpatient hospitalization (other than hospitalization as a formal voluntary patient as provided by law) only if I have authorized the Patient Advocate to do so by signing immediately below. I understand that if I am hospitalized as a formal voluntary patient under an application executed by my Patient Advocate, I retain the right to terminate the hospitalization as provided by law:

If you give the consent described above, sign here: _____

I understand that I may revoke my Patient Advocate designation at any time and in any manner sufficient to communicate intent to revoke. However, I may choose to waive my right to revoke my Patient Advocate designation as to the power to exercise mental health treatment decisions by making this waiver as part of my designation document. If I waive this right to revoke, I understand that mental health treatment provided to me shall not continue for more than 30 consecutive days, and that the waiver does not affect my rights under section 419 of the Mental Health Code, 1974 PA 258, MCL 330.1419, or as it may be amended or superseded by another statute.

If you waive your right to revoke your Patient Advocate designation as to the power to exercise mental health treatment decisions, sign here: _____

This document is to be treated as a Durable Power of Attorney for Health Care and shall survive 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 and/or mental health 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 concerning 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 _____

Name _____
type or print

Address _____

Witness Statement and Signature

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.

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

Keep the signed original with your personal papers at home. Give signed copies to your doctor, family, and the medical facility where you are being treated and to Patient Advocates.

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, 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, or a community mental health services program or hospital that is providing mental health treatment to the person, and that I am at least eighteen years old.

Witness

Sign Name _____ Sign Name _____

Name _____ Name _____
Type or print Type or print

Address _____ Address _____

_____ Date _____ Date _____

Sign Name _____

Name _____
Type or print

Address _____

_____ Date _____

These restrictions are required by the Patient Advocate Act of 1990, P.A. No. 312 (MCLA 700.496) and Public Act 386, 1998.