

Durable Power of Attorney for Health Care

DESIGNATION OF PATIENT ADVOCATE FORM & INSTRUCTION

PUBLISHED BY:



**To My Family, Doctors,
Mental Health Professionals
and All Concerned
with My Care:**

The instructions in this document
express my wishes about my
medical and mental health care.

I want my family, doctors,
mental health professionals and
everyone else concerned with my care
to act in accordance with them.



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INDIVIDUALS MAY PHOTOCOPY THIS
COMPLETED FORM FOR PERSONAL USE ONLY.

OTHER PHOTOCOPYING OF THIS FORM IS PROHIBITED
AND MAY RESULT IN A NON-VALID DOCUMENT.

Name Your Patient Advocate

Here you 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 18 years old and of sound mind. You may also name one or more persons to act as "Successor Patient Advocate(s)" if your first choice cannot. You may revoke your appointment of a Patient Advocate at any time.

Appointment of Patient Advocate

I, _____
PRINT YOUR NAME

do hereby appoint the following person to be my Patient Advocate:

PRINT PATIENT ADVOCATE'S NAME

PRINT PATIENT ADVOCATE'S ADDRESS

Appointment of Successor Patient Advocate(s)

I appoint the following person(s) as my Successor Patient Advocate in the event 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.

PRINT SUCCESSOR PATIENT ADVOCATE'S NAME

PRINT SUCCESSOR PATIENT ADVOCATE'S ADDRESS

PRINT SUCCESSOR PATIENT ADVOCATE'S NAME

PRINT SUCCESSOR PATIENT ADVOCATE'S ADDRESS

- My Patient Advocate or Successor Patient Advocate may delegate his/her powers to the next Successor Patient Advocate if he/she is not able to act.
- My Patient Advocate or Successor Patient Advocate may act only if I am unable to participate in making decisions regarding my medical, or as applicable, mental health treatment.

Instructions for Your Care

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

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.

1. General Instructions

My Patient Advocate shall have the authority to make all decisions and to take all actions regarding my care, custody, medical 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.** Employ and discharge physicians, nurses, therapists, any other health care providers, mental health professionals and other providers, and arrange to pay them reasonable compensation.

NOTE: *Your Patient Advocate has the right to make arrangements for your care but is not required personally to pay the cost of your care.*

- C.** Consent to, refuse or withdraw for me 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 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 recorded below and on the following pages.

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

A. Specific Instructions Regarding Care I DO want:

B. Specific Instructions Regarding Care I DO NOT want:

C. Specific Instructions 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 DO 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 without regard to my condition, the chances I have for recovery, or the cost of my care, and I direct life-sustaining treatment to be provided in order to prolong my life.

» If this statement reflects your desires, sign here:

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:

E. Specific Instructions Regarding Anatomical Gifts

NOTE: You do not have to include any specific instructions regarding Medical Examinations or Anatomical Gifts. Discuss these choices with your doctor.

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 transplantation needed by another individual; for medical or dental education, research, or the advancement of medical or dental science; for anatomical study; or for any other purpose then permitted by law. This authority granted to my Patient Advocate shall remain following my death.

» **If this statement reflects your desires, sign here:**

F. Specific Instructions Regarding Mental Health Treatment

NOTE: You do not have to choose any of the specific instructions regarding mental health treatments. You may choose any one or more of these instructions if you wish to do so. Discuss these choices with your doctor.

- I understand that I may, but am not required to, designate a physician and/or mental health practitioner 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 the examination and determination shall be made by another physician or mental health practitioner, as applicable.
- I prefer that the following physician(s) and/or mental health practitioner(s) conduct the examination (no designation is made if left blank):

PRINT PHYSICIAN OR MENTAL HEALTH PRACTITIONER'S NAME

PRINT PHYSICIAN OR MENTAL HEALTH PRACTITIONER'S NAME

- With regard to mental health treatment decisions, I expressly authorize my Patient Advocate to consent to the forced administration of medication or to inpatient hospitalization if a physician and/or mental health practitioner determine that I cannot give informed consent for the mental health care. However, I retain my right to terminate a hospitalization as a formal voluntary patient under an application executed by my Patient Advocate.

» **Sign your name here if you give the consent described above:**

G. Waiver

I understand that I may choose to waive my right to revoke my Patient Advocate designation regarding the power to make mental health treatment decisions for me only by making this waiver in this document. Even if I waive this right to revoke, I understand that by law if mental health treatment is being provided to me, it shall not continue for more than 30 consecutive days, and that this waiver does not affect my right to terminate my hospitalization as a formal voluntary patient.

» **Sign here if you waive your right to revoke your Patient Advocate designation regarding the power to make mental health treatment decisions for you:**

H. 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 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 may be relied upon as if 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.

» Sign your name here if you give the consent described above:

SIGNATURE

DATE

PRINT NAME

STREET ADDRESS

CITY / STATE / ZIP CODE

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

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

Witnesses

NOTE: Sign and date on the previous page in the presence of at least two witnesses who meet the requirements listed in the witness statement listed below. 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.

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, partner, 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 of a community mental health services program or hospital that is providing mental health services to him/her, and that I am at least 18 years old.

Witness 1

SIGNATURE

DATE

PRINT NAME

STREET ADDRESS

CITY / STATE / ZIP CODE

Witness 2

SIGNATURE

DATE

PRINT NAME

STREET ADDRESS

CITY / STATE / ZIP CODE

Advocate(s) Acceptance

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

I, _____ do hereby agree to be the Patient Advocate for:
PRINT PATIENT ADVOCATE'S NAME

Name: _____
PRINT PATIENT'S NAME (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 or mental health treatment decisions, as applicable.
- B.** A Patient Advocate shall 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.** 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 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 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 or mental health treatment decisions are presumed to be in the Patient's best interests.
- 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 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.** 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.
- J.** A Patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, 1978 PA 368, MCL 333.20201.
- 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.

Patient Advocate and Successor Advocate(s)

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

SIGNATURE

DATE

PRINT NAME (FIRST, MIDDLE INITIAL, LAST)

ADDRESS

HOME PHONE

WORK PHONE

Successor Patient Advocate

SIGNATURE

DATE

PRINT NAME (FIRST, MIDDLE INITIAL, LAST)

ADDRESS

HOME PHONE

WORK PHONE

Successor Patient Advocate

SIGNATURE

DATE

PRINT NAME (FIRST, MIDDLE INITIAL, LAST)

ADDRESS

HOME PHONE

WORK PHONE

Review & Reaffirm

You should review this document from time to time and when there is a change in your health or family status. When you review it, if it still expresses your intent, sign and date below 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 a copy of the old version.

Reaffirmed

DATE	SIGNATURE
DATE	SIGNATURE