Advance Directive

Durable Power of Attorney for Health Care

Patient Advocate Designation

Introduction

This document includes the required content to be legally recognized, in the state of Michigan, as an Advance Directive which includes the appointment of a Patient Advocate.

This **Advance Directive** allows you to appoint a person (and alternates) to make your healthcare decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate**. This document gives your Patient Advocate authority to make your decisions *only when you have been determined unable to make your own decisions by two physicians, or a physician and a licensed psychologist.*

This form is referred to as the *"Durable Power of Attorney **for Health Care**"* (DPOA-HC) and should not be confused with a *"Durable Power of Attorney"* (DPOA) which relates to decisions about your financial matters. Your Patient Advocate named in this DPOA-HC does not have the authority to make your financial or other business decisions.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values and this document with your Patient Advocate.**

If you do not closely involve your Patient Advocate, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

Scanning Information: Please note, only and all of pages numbered 1-6 in this document should be scanned into the Patient's medical record. Do not include this cover page and the wallet card page.

For more information or assistance in completing this Advance Directive, contact:
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Courtesy of Covenant HealthCare, Saginaw, MI • DPOA-HC

Bus. Dev. (AQ/RF) Rev. 3/21 13602 PF00180

PF00180 (R 12/20)

Advance Directive

Durable Power of Attorney for Health Care • Patient Advocate Designation

This is an Advance Directive for:

Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

Appointment of Patient Advocate

*If I am no longer able to make my own healthcare decisions, this document names the person(s) I choose to make these choices for me. This person will be my Patient Advocate and will make my health-care decisions **only** when I am determined to be unable of making healthcare decisions. I understand that it is important to discuss my health and wishes for healthcare treatment with my Patient Advocate.*

I appoint the following person as my Primary Patient Advocate:

I understand my Patient Advocate(s) must be at least eighteen years old and of sound mind.

Name: _____ Relationship to Patient: _____

Address/City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Appointment of Successor Patient Advocate(s)

I appoint the following person(s), in the order listed, to be my Successor Patient Advocate if my Primary Patient Advocate named above 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 Primary Patient Advocate.

First Successor Patient Advocate:

Name: _____ Relationship to Patient: _____

Address/City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Second Successor Patient Advocate:

Name: _____ Relationship to Patient: _____

Address/City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Third Successor Patient Advocate:

Name: _____ Relationship to Patient: _____

Address/City/State/Zip: _____

Contact #: Home:_____ Cell: _____

My Choices: Instructions for Care

Section 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 healthcare providers (Please note: The Patient Advocate is not responsible for payment of services).

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 may include, but is not limited to: **Ventilator (breathing machine), cardiopulmonary resuscitation (CPR), nutritional tube feedings, intravenous hydration, kidney dialysis and blood pressure or antibiotic medications**. I also understand that these decisions could or would allow me to die.

Sections 2-7 are optional to complete. If you do not want to complete a section, initial the bottom line which states *"I choose not to complete this section"*.

Section 2. Resuscitation *(optional)*

Resuscitation refers to care that may be provided if your heart and breathing have stopped. This care includes: Chest compressions, defibrillation (electrical shock), specific cardiac arrest medications and intubation/mechanical ventilation (being placed on a breathing machine).

If my heart and breathing were to suddenly stop:

☐ **I DO WANT** to be resuscitated.

☐ **I DO WANT** to be resuscitated, unless any of the following medical conditions exist:

- An illness or injury that cannot be cured and I am dying.
- No reasonable chance of survival.
- The quality of life I have expressed to my Patient Advocate(s) as being important to me is unlikely to be achievable.

☐ **I DO NOT WANT** to be resuscitated but instead would like to allow natural death.

Please note: If you choose to not be resuscitated, this wish will need to be shared verbally on each admission to a medical facility and will require an Out of Hospital DNR order to be honored by first responders (ambulance, fire department, etc.)

_____ *(initials) I choose not to complete this section.*

Section 3. Life-Sustaining Treatment *(optional)*

Examples of life-sustaining treatment include but are not limited to: Tube-feeding, dialysis and artificial hydration.

If following a sudden medical event, my physicians believe that with my medical condition it is unlikely I would recover to know who I am or who I am with:

☐ **I DO WANT** life-sustaining treatments continued or initiated.

☐ **I DO NOT WANT** life-sustaining treatments continued or initiated.

_____ *(initials) I choose not to complete this section.*

Section 4. Organ Donation *(optional)*

☐ I am registered on the Michigan Donor Registration and/or on my Michigan driver's license.

☐ I am not registered but authorize my Patient Advocate to donate any parts of my body.

☐ I am not registered but authorize my Patient Advocate to donate any parts of my body EXCEPT those listed here: _____ .

☐ I do not wish to donate my organs.

_____ *(initials) I choose not to complete this section.*

Section 5. Guardianship *(optional)*

☐ In the event that I am unable to make my own decisions, I would want the person I have named as my Primary Patient Advocate to be appointed as my legal guardian as well.*

☐ In the event that I am unable to make my own decisions, I would want the individual(s) listed below to have guardianship over decisions concerning me – other than healthcare.*

_____

**Please note: The above two options do not automatically appoint a guardian, but rather provides the court with a statement of your wishes. A court order is necessary to finalize this appointment.*

_____ *(initials) I choose not to complete this section.*

Section 6. Mental Health *(optional)*

☐ I have included my wishes for mental health specific treatment in this document. Please see the completed Mental Health Addendum on page 3a.

_____ *(initials) I choose not to complete this section.*

Section 7: Additional Specific Instructions *(optional)*

I want my Patient Advocate to follow these specific instructions:

_____

_____

_____

_____

_____ *(initials) I choose not to complete this section.*

Section 8. Persons I Want My Advocate to Include in the Decision Process *(optional)*

This person is desired to have input on decisions but will not have decision-making authority.

I ask that my Patient Advocate make reasonable attempts to include the following person(s) in my healthcare decisions if there is time:

_____

_____

Signature

- 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.
- 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 and date below in the presence of TWO witnesses who meet the requirements below.

Signature: Sign Name: _____ Date:_____

Print Name:_____

Witness Statement and Signatures

If you do not personally know the person signing this document, ask for identification, such as a driver's license or patient arm band.

I know this person to be the individual identified as the "Patient" signing this form. I believe him or her to be of sound mind and at least eighteen years old. **I personally saw him or her sign this document**, and I believe he or she did so under no duress, fraud or undue influence. In signing this document as a witness, I declare that I am:

- At least 18 years of age
- Not the Patient Advocate, or a Successor Patient Advocate appointed in this document
- Not the Patient's spouse, parent, child, grandchild or presumptive heir
- Not a known beneficiary of his/her will at the time of witnessing
- Not an employee of a health or life insurance provider for the person who signed
- Not an employee of a healthcare facility that is treating the Patient at this time
- Not a healthcare provider currently involved in the treatment of the Patient

Witness Signatures:

1. Sign Name: _____ Print Name:_____

   Address: _____ Date:_____

2. Sign Name: _____ Print Name:_____

   Address: _____ Date:_____

Notary: ONLY required for residents of Missouri, North Carolina, South Carolina and West Virginia

STATE OF:_____

COUNTY OF:_____

On this _____ day of _____, 20_____,

the said: _____,

foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County a foresaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My commission expires on: _____

Notary Public Signature:_____

Acceptance of Patient Advocate(s)

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

I agree to be the Patient Advocate for _____ (name of person document is created for).

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 the Patient would not have chosen on his or her 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, even if these were the Patient's wishes.

d. A Patient Advocate may make decisions 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.

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 to further the Patient's best interests. 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.

g. A Patient may revoke his or her designation at any time and in any manner sufficient to communicate his or her intent to revoke.

h. A Patient Advocate may revoke his or her acceptance of the designation at any time and in any manner to communicate an intent to revoke.

Patient Advocate Signatures

Before agreeing to accept the Patient Advocate responsibility, you should:

1. **Carefully read this completed form.**
2. **Discuss, in detail, the person's values and wishes, so that you can gain the information that will allow you to make the decision(s) he or she would desire.**

Primary Patient Advocate: Date: _____

Sign Name: _____ Print Name: _____

First Successor Patient Advocate: Date: _____

Sign Name: _____ Print Name: _____

Second Successor Patient Advocate: Date: _____

Sign Name: _____ Print Name: _____

Third Successor Patient Advocate: Date: _____

Sign Name: _____ Print Name: _____

Making Changes

NOTE: If your wishes change, you may revoke your Patient Advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

Contact information for your Advocate(s) may be revised on the original and on photocopies without replacing the entire form. For additional changes, a new form will need to be completed. If you decide to create a new document, please be sure to provide copies to all parties who have a copy of the old document.

It is recommended that you review this document with your annual physical exam and whenever one of the events below occur:

- **Decade –** when you start each new decade of your life (30, 40, 50, 60, 70, 80…years of age)
- **Death –** whenever you experience the death of someone close to you
- **Divorce –** if you experience a divorce or other major family change
- **Diagnosis –** if you are diagnosed with a serious health condition or experience a life-threatening injury
- **Decline –** if you have decline of an existing health condition, especially if you live alone

When you review this document and it still reflects you wishes, sign and date here in the Reaffirmed section below to show the content is still correct. These signatures do not need to be witnessed.

REAFFIRMED

Date_____ Signature _____

Date_____ Signature _____

Date_____ Signature _____

Date_____ Signature _____

Who Should Have a Copy of This Document?

It is important to have your Advance Directive available when needed in an emergency. For this reason, the following people and places are recommended to have a copy of your Advance Directive.

- **Your physician**
- **Hospital(s) most likely to provide care**
- **Each Patient Advocate**
- **Family member(s) close to you**
- **Your lawyer**
- **Keep a copy in the glove compartment of your vehicle.**
- **Keep a copy in your home where it can be easily found if you need to go to the hospital or call 911.**

I plan to provide copies of this document to *(check box once completed)*:

_____ ☐ _____ ☐

_____ ☐ _____ ☐

_____ ☐ _____ ☐

_____ ☐ _____ ☐

Create Your Own Personal Wallet Card

The attached wallet card is provided to alert medical personnel to the existence of a Durable Power of Attorney for Health Care (DPOA-HC) in the event you require medical treatment and are unable to verbally inform healthcare providers that a Patient Advocate has been appointed to act on your behalf. It is recommended that you complete the card 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. Space is also provided on the card to write in the name and telephone number of a third person (other) who has a copy of your DPOA-HC. This may be the person you 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 DPOA-HC form.
3. Be sure to update the information on the card if there are changes.

Carefully cut out the card along the solid line, fold it in half along the dotted line and tape it at the top.

NOTICE TO ALL MEDICAL PERSONNEL

I have an Advance Directive

Patient’s Name:_____

A copy of my Advance Directive can be found at:

_____

One of the persons listed on the reverse of this card who has a copy of my Durable Power of Attorney for Health Care (DPOA-HC) should be contacted immediately, in the order listed (see reverse).

Fold here ▶

Primary Patient Advocate:_____

Cell #: _____ Alternate #: _____

First Successor Advocate: _____

Cell #: _____ Alternate #: _____

Other:_____

Cell #: _____ Alternate #: _____

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