



Advance Care Planning

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Planning for Future Health Care Decisions

Advance Directive:
Choosing My Patient Advocate
(Durable Power of Attorney for Health Care)

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FORMS INCLUDED

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This “Advance Directive: Choosing My Patient Advocate” form has been designed to meet all of the applicable requirements under the Michigan Durable Power of Attorney for Health Care law, MCL 700.5506 et seq.

When completed correctly, this form may be used at any Michigan health care facility and serve to guide health care providers as to your Advance Care Planning wishes.

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After completing this document, please return it to:

Advance Care Planning
c/o Medical Records
Saint Joseph Mercy Health System
5301 East Huron River Drive
P.O. Box 995
Ann Arbor, Michigan 48106-0995

Medical Records Fax
734-712-7387

Questions? Call 734-712-8417.

A BRIEF GUIDE TO ADVANCE CARE PLANNING

Thank you for taking time to learn about Patient advocacy and advance care planning. There are two major roles - Patient and Patient Advocate. Both roles are important. The Patient must thoughtfully identify his/her goals and values and choose an advocate. The Patient Advocate needs to learn the Patient's goals and values as well as realize the responsibility involved.

This packet contains three documents:

1. **“A Brief Guide”** (which you are reading now): This provides an overview of the process and instructions for completing the forms (see pages 2 and 3). We strongly suggest that both the Patient and the Patient Advocate read this guide and discuss it with each other.
2. **“Choosing My Patient Advocate”**: This is the form the **Patient** will complete to name and provide instructions to the Patient Advocate.
3. **“Accepting the Role of Patient Advocate”**: This is the form the **Patient Advocate** will complete indicating that he or she is willing to serve in that role.

INTRODUCTION

As an adult with the ability to make your own medical decisions, you can accept, refuse or stop medical treatment. If you lose the ability to make your own medical decisions (for instance, because of an accident or illness), someone else will have to make those decisions for you. You can choose the person you want to make those decisions – that person is called your “Patient Advocate” – and give that person information about your preferences, values, beliefs, wishes and goals that will help him or her make the decisions you want made. The “Choosing My Patient Advocate” form (sometimes called an Advance Directive) allows you to identify the Patient Advocate you have chosen. It also instructs your Patient Advocate so he or she can act on your behalf.

It is important for both you and your Patient Advocate to understand that your Patient Advocate makes decisions only when you lack the ability to do so. In Michigan, two physicians, one of whom should be your attending physician, have to examine you and declare that you lack decision-making ability (also called decision-making capacity) before a Patient Advocate can act on your behalf.

It is also important for you and your Patient Advocate to know that by law in Michigan:

- you can designate an Alternate Patient Advocate to act in case your first choice of Patient Advocate is unavailable, but at any given time only one person can act as your Patient Advocate;
- your Patient Advocate must sign the form entitled “Accepting the Role of Patient Advocate” (or a similar form) before acting on your behalf; and
- your Patient Advocate can make a decision to refuse or stop life-sustaining treatment only if you have clearly expressed that he or she is permitted to do so.

INSTRUCTIONS FOR “CHOOSING MY PATIENT ADVOCATE”

Section 1: Naming Your Patient Advocate

On page 5, you will name your Patient Advocate. You may also, if you wish, name an Alternate Patient Advocate in the event your first choice for Patient Advocate is no longer able or willing to serve.

Take time to think about who would be a good Patient Advocate for you.

- **Your Patient Advocate can be a spouse or relative but doesn’t have to be – for some people, a friend, pastor or co-worker might be the right choice. (Your doctors, or any employees of your doctors or of the hospital you go to, usually cannot serve as your Patient Advocate.)**
- **Your Patient Advocate must be at least 18 years of age.**

- **He or she should be someone with whom you feel comfortable discussing your preferences, values, wishes and goals.**
- **He or she needs to be willing to follow those preferences even if that is difficult or stressful and even if the decisions you would want made are different from the ones he or she would make for his or her own medical care.**
- **Your Patient Advocate must be willing to accept the significant responsibility that comes with this role.**

In sum, a good Patient Advocate must be able to serve as your voice and honor your wishes.

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Section 2: Instructing Your Patient Advocate

On page 6, you can inform your Patient Advocate about your preferences, values, wishes and goals. You can give general instructions, specific instructions, or a combination of both.

It is important to let your Patient Advocate know any particular concerns you have about medical treatment, especially about treatments you would refuse or want stopped. For example, you might indicate that you would not want breathing machines, feeding tubes, or IV fluids if you suffer serious brain injury and do not know who you are or where you are. **If your Patient Advocate does not know what you would want, it is his or her duty to decide, in consultation with your medical team, what is in your best interest.**

In order to serve you well and to be able to make the medical decisions you would want made, your Patient Advocate needs to know a great deal about you. The discussions between you and the person you choose to be your Patient Advocate will be unique, just as your preferences, values, wishes, goals, medical history and personal experiences are unique.

Among the topics you might want to discuss with your Patient Advocate are:

- **spiritual and religious beliefs, especially those that concern illness and dying;**
- **experiences you have had in the past with family or loved ones who were ill;**
- **fears or concerns you have about illness, disability or death;**
- **your understanding of any medical conditions or diseases you have;**
- **what gives your life meaning; and**
- **what sustains you when you face serious challenges.**

Finally, it is important to understand that under Michigan law, your Patient Advocate can only make a decision to refuse or stop life-sustaining treatment if you have clearly given him or her specific permission to make that decision.

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Section 3: Organ Donation and Autopsy

On page 7, you may, if you wish, state your instructions for organ donation and/or autopsy after your death. By law, these instructions must be honored by your Patient Advocate and your family.

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Section 4: Signing the Form and Having It Witnessed

If you are satisfied with your choice of Patient Advocate and with the guidance you have provided to your Patient Advocate, you will need to sign and date the statement in Section 4 in the presence of at least two witnesses. Neither witness can be your Patient Advocate, spouse, parent, brother, sister, child, grandchild, heir, physician or employee of your physician or hospital. These witnesses then need to sign and date the form in the designated space. By signing, they are attesting that they witnessed your signing the Patient Advocate form and

that they believe you to be of sound mind and under no duress, fraud or undue influence.

Once the “Choosing My Patient Advocate” form is completed, signed, and witnessed, please make sure that a photocopy of the form is provided to Saint Joseph Mercy Health System so that it is available to your doctors and other health care providers. On request, it will be sent to any other doctor or health care facility providing care to you. You may give the form to your Advance Care Planning facilitator, or you may mail or fax a photocopy to Saint Joseph Mercy Health System at the address and fax number on the form.

INSTRUCTIONS FOR “ACCEPTING THE ROLE OF PATIENT ADVOCATE”

Under Michigan law, your Patient Advocate (or Alternate Patient Advocate) cannot act on your behalf until he/she receives a copy of your Patient Advocate form and accepts the role of Patient Advocate in writing. That acceptance must be in a certain format required by law and must contain certain statements, as written on the “Accepting the Role of Patient Advocate” form. Your Patient Advocate (or Alternate Patient Advocate) must read and sign those statements on this form if he/she is willing to take on that role.

You should provide your Patient Advocate with:

- a copy of “The Brief Guide”

- a completed copy of the “Choosing My Patient Advocate” form, and
- “Accepting the Role of Patient Advocate” form.

Ask your Patient Advocate to carefully read those documents and, if he/she is willing to serve as your Patient Advocate, to sign your form under “Accepting the Role of Patient Advocate”. Then mail or fax a photocopy of the completed forms to Saint Joseph Mercy Health System at the address and fax number on the form. On request, that form, along with the “Choosing My Patient Advocate” form, will be sent to any other doctor or health care facility providing care to you.

CHOOSING MY PATIENT ADVOCATE

This form expresses my wishes about my medical and mental health care. I want my family, doctors, other health care providers, and anyone else concerned with my care to follow my wishes. For this reason, I give Saint Joseph Mercy Health System permission to send a copy of this document to other doctors, hospitals and health care providers that provide medical care to me.

Section 1: Naming My Patient Advocate

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

Name: _____

Relationship: _____

Address: _____

City and Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Naming an Alternate Patient Advocate (Optional)

In case the person named above cannot be contacted or is otherwise unavailable or unable to serve as my Patient Advocate, I choose the person named below to serve as my Alternate Patient Advocate.

Name: _____

Relationship: _____

Address: _____

City and Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Please return this completed document to your hospital.
See instructions on the inside front cover.

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Section 2: Instructing My Patient Advocate

A. General Instructions

I want my Patient Advocate to be able to:

- Make choices for me regarding my medical care or services, such as testing, medications, surgery and hospitalization. If treatment has been started, he or she can keep it going or have it stopped depending upon my specific instructions (see below) or, if I have included no specific instructions, my best interest. This authority includes decisions about life-sustaining treatments. Life-sustaining treatments may include, but is not limited to, breathing machines and the giving of fluids and nutrition by use of tubes;
- Interpret any instructions I have given in this form (or in other discussions) according to his or her understanding of my wishes and values;
- Review and release my medical records, mental health records and personal files as needed for my medical care;
- Arrange for my medical care, treatment and hospitalization in Michigan or any other state, as he/she thinks appropriate;
- Determine which health professionals and organizations may provide my medical treatment; and
- Make choices about my mental health treatment, including the ability to consent to forced administration of medicines and inpatient hospitalization.

B. Specific Instructions (Optional)

I give my Patient Advocate permission to make the following decisions.

Life–Sustaining Treatment

(You may, if you wish, give your Patient Advocate *specific permission to refuse life-sustaining treatment by initialing below the following statement.*)

If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with my family, friends and environment, I want to stop or withhold treatments that might be used to prolong my existence. Examples of treatments I would not want if I were to reach this point could include, but are not limited to, tube feedings, IV hydration, ventilators, CPR and antibiotics.

My initials: _____

Other Specific Instructions

I want my Patient Advocate to follow the specific instructions below, which may limit the authority described above in the General Instructions (Section 2, Part A).

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Section 3: Organ Donation and Autopsy

Below are the instructions I want followed by my Patient Advocate after my death. If my Patient Advocate is unable or unavailable to make these decisions, I ask that my next of kin and physician follow these requests if possible.

Donation of My Organs or Tissue:

Initial only one.

___ I wish to donate any organs or tissue if I am a candidate.

___ 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.

Autopsy:

***Initial only A. or B. below.
(You may chose both options under B.)***

A. ___ I do not want an autopsy performed on me, unless it is required by law.

OR

B. Initial one or both options below.

___ I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future health care decisions.

___ I would accept an autopsy if it can help the advancement of medicine or medical education.

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Section 4: Signing the Patient Advocate Form and Having It Witnessed

Section 4 must be completed, signed and dated by the Patient and two witnesses on the same day and time or it will not be valid.

Signature of the Patient

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 18 years old and of sound mind.

Signature: _____

Date: _____ Time: _____

Address: _____

City and Zip: _____

Signature of the Witnesses

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 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 appointed by the person signing this document.
- Not related to the person signing this document by blood, marriage or adoption.
- 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: _____ Time: _____

Name (please print): _____

Relationship: _____

Address: _____

City and Zip: _____

Witness number 2:

Signature: _____

Date: _____ Time: _____

Name (please print): _____

Relationship: _____

Address: _____

City and Zip: _____

Please return this completed document to your hospital. *See instructions on the inside front cover.*

ACCEPTING THE ROLE OF PATIENT ADVOCATE

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. the document entitled “A Brief Guide to Advance Care Planning” on page 1, which provides important information and instructions, and
2. a copy of the form the Patient filled out entitled “Choosing My Patient Advocate” on page 5.

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 statement on page 12.

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 “Choosing My 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 understands 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 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, the designated Patient Advocate, am not able or available to make a decision, I delegate my authority to the person the Patient has designed as Alternate Patient Advocate. The Alternate Patient Advocate is authorized to act until I become available to act.

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Patient Advocate

The information below must be completed, signed and dated by the Patient Advocate after the Patient completes Section 4 or it will not be valid.

Signature: _____

Date: _____ Time: _____

Name (please print): _____

Address: _____

City and Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

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Alternate Patient Advocate

Signature: _____

Date: _____ Time: _____

Name (please print): _____

Address: _____

City and Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Please return this completed document to your hospital.
See instructions on the inside front cover.

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Notes

