



# MY INSTRUCTIONS TO HEALTH CARE PROVIDERS

## WHAT IS THE PURPOSE OF THIS BOOKLET?

This booklet is yours to keep. It is your way of communicating your wishes about medical and mental health treatment you want or do not want, in the event you are unable to express them yourself. This booklet serves as a guide to your health care team. It is a legal document and can be used in any health care setting (hospital or nursing home). As a guide, it should be reviewed by your health care team every time you enter a facility, so the plan of care your health care team creates for you is consistent with your wishes and goals.

### Always retain your original.

Keep a record of places you have presented these advance directives in the event you wish to revoke/change your wishes.

---

---

---

---

## The five main areas covered in this booklet

1. Naming a **patient advocate** for a time when you cannot speak for yourself ..... **page 2**
2. Indicating your current health care wishes ..... **page 3**
3. Indicating your future health care wishes when you may not be able to speak for yourself (an **advance directive**) ..... **page 4**
4. Noting your wishes about organ donation, and registering with the Michigan Organ, Tissue and Eye Donor Registry ..... **page 5**
5. Signed patient advocate form ..... **pages 6–7**

# WHY DO I NEED TO APPOINT A PATIENT ADVOCATE?



By naming a patient advocate, you provide the name of a person you trust to make health and mental health treatment decisions for you when you are not able to make decisions on your own.

When you choose someone who is aware of your wishes, he/she can participate in discussions and weigh the pros and cons of treatment decisions based on your requests and values.

Your patient advocate can make decisions for you whenever you cannot decide for yourself, even if your decision-making ability is only temporarily affected. You can define how much or how little authority you want your patient advocate to have. You can also name people to act as alternate advocates if your primary advocate cannot act for you.

Without a designated patient advocate, the responsibility to make your medical decisions will fall to your next of kin. Sometimes, when more than one person is involved in decision-making, there can be difficulty reaching an agreement. This could cause delays in care and possibly conflict within your family.



# YOUR PATIENT ADVOCATE



Your patient advocate should be someone:

- who is 18 years or older.
- you can trust, such as a spouse, family member or close friend.
- with whom you can discuss your wishes.
- who will ensure your wishes are honored.
- who can be contacted quickly when a decision is needed.

It is also a good idea to name an alternate advocate in case your first advocate is not available. Of course, only appoint an alternate if you fully trust them to act faithfully as your advocate, and you have talked to them about serving as your patient advocate.

Remember to discuss your choices with your advocate and provide them with a copy of this booklet.

You have the right to revoke or take away the authority of your patient advocate at any time.

## **A patient advocate can, with your designation, and at that time when you are unable to make your own decisions:**

- have access to and release your medical records.
- give informed consent or informed refusal for medical and mental health treatment decisions on your behalf.
- authorize the withdrawal or withholding of life-sustaining treatment and pursuit of comfort measures.
- authorize admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service.
- make anatomical gifts of part or all of your body for medical purposes.



## AT THE PRESENT TIME, CONSIDERING MY CURRENT STATE OF HEALTH, WHAT I WANT NOW



This section allows you to make a determination about your cardiopulmonary resuscitation (CPR) status based on your current health.

The hospital staff will always perform cardiopulmonary resuscitation (CPR) if there is any doubt about your wishes.

It is important to notify your physicians, family and advocate of your wishes. It is equally important that you consider and discuss with your physicians, family and advocate of your wishes regarding other aggressive medical interventions, including dialysis, artificial nutrition and hydration and mechanical ventilation.

Some people will have determined, following discussion with their physician, that they do not want to have CPR performed if their heart or breathing were to stop. This section allows you to communicate that wish to your care givers.

### CPR

Cardiopulmonary resuscitation (CPR) is the compression of your heart and artificial breathing used in an attempt to restore circulation. Electrical shocks (defibrillation) may also be used to get the heart to start beating again.

#### *Initial one of the following:*

- \_\_\_\_\_ Yes, I do want CPR and defibrillation.  
**CPR includes the use of mechanical ventilation.**
- \_\_\_\_\_ No, I do not want CPR or defibrillation if my heart were to stop. This will not prevent me from receiving other appropriate medical interventions.

**In a non-crisis state, a decision regarding mechanical ventilation may be necessary.**

### Respirator/ventilator

This machine provides artificial ventilation to support you when you cannot breathe on your own. It can be used for a temporary period of time while you recover and regain the strength to breathe on your own.

#### *Initial one of the following:*

- \_\_\_\_\_ Yes, I do want to be placed on a respirator/ventilator if necessary.
- \_\_\_\_\_ Yes, I do want to be placed temporarily on a ventilator/respirator. However, should my condition fail to improve, I give my patient advocate and physician permission to withdraw this treatment and understand that withdrawing this treatment may result in my death.
- \_\_\_\_\_ No, I do not want to be placed on a respirator/ventilator.

**Initial page upon completion \_\_\_\_\_**

# IN THE FUTURE, IF I AM NOT CAPABLE OF MAKING A DECISION, THESE ARE MY DIRECTIVES



This directive allows you to maintain control over health care decisions that are important to you if you cannot make or communicate decisions because of an end-of-life illness or injury.

Think about what makes life worth living for you. For example, being able to talk to your loved ones, being able to take care of yourself, or being able to live without being hooked up to machines. Under what circumstances would you say life is NOT worth living (initial all that apply)

\_\_\_ If I will most likely not wake up from a coma.

\_\_\_ If I can't take care of myself.

\_\_\_ If I am in pain.

\_\_\_ If I cannot live without being hooked up to machines.

\_\_\_ I am not sure.

\_\_\_ Other:

---

---

---



## These are my instructions regarding end-of-life treatment.

*Initial only one of the following statements:*

1.

### Directive to treat for comfort:

\_\_\_ If I should have an injury, disease or illness regarded by my physician as incurable or terminal, and if my physician determines that the application and maintenance of life sustaining procedures would serve only to prolong the dying process, I direct that such procedures **be withheld and withdrawn**. Under these circumstances, I request that the **goal of therapy be changed from a goal of cure to a goal of comfort**.

I want treatment limited to measures that will provide me with the maximum comfort and freedom from pain, anxiety and breathlessness.

2.

### Choice To Prolong Life:

\_\_\_ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

Initial page upon completion \_\_\_\_\_



# MY INSTRUCTIONS FOR DONATION OF ORGANS AT DEATH



Because this document addresses those sensitive decisions related to the end of life, this section allows you to share your wishes regarding organ and tissue donation. Such decisions are personal and private, but decisions all families will be asked to make. This page will provide your family direction.

**While it is important your patient advocate be aware of your intention regarding organ donation, the completion of this page is optional and not essential to your advance directive.**



## **The following are my wishes regarding organ donation.**

### *Initial one of the following:*

Upon my death:

\_\_\_\_\_ Yes, I wish to donate needed organs or tissues.

\_\_\_\_\_ No, I do not wish to donate any organs or tissues.

It is important that you tell your family and friends your wishes regarding organ donation. Should you decide to be a donor, you can place your name on the donor registry for the State of Michigan. The Organ, Tissue and Eye Donor Registry is a confidential, 24-hour-a-day computerized database that documents your wishes regarding organ donation. You can call the Gift of Life at **800-482-4881** for more information.

**Initial page upon completion \_\_\_\_\_**

# SIGNING THE DOCUMENT



**The document must be signed and dated in the presence of two witnesses.**

## The witnesses cannot be:

- an employee or volunteer of your health care provider
- your spouse, parent, child, grandchild, brother or sister
- an heir of your estate
- your patient advocate
- an employee of a nursing home where you reside
- under 18 years of age

## Signing the document:

By signing this document I intend to create a Health Care Power of Attorney. It is effective only during the period in which I cannot make or communicate a choice regarding a particular health care decision.

This document will only become effective if my attending physician and another physician or licensed psychologist determine that I am unable to make choices about my health care.

The authority of my patient advocate to make an anatomical gift remains exercisable after my death. By signing here I indicate that I understand the contents of this document and the power and authority I have given my patient advocate.

I sign my name to this document on this \_\_\_\_\_

day of \_\_\_\_\_, 20 \_\_\_\_\_

My signature \_\_\_\_\_

My name (print) \_\_\_\_\_

My current address \_\_\_\_\_

\_\_\_\_\_

My date of birth \_\_\_\_\_

My home phone \_\_\_\_\_

My cell phone \_\_\_\_\_

## **Witness statement**

*I declare that the person who signed this document signed it in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.*

## **I am not:**

- the person appointed as the patient advocate by this document.
- the patient's health care provider.
- an employee of the patient's health care provider.
- an employee of a life or health insurance provider for the patient.
- related to the patient by blood, marriage, or adoption.
- to the best of my knowledge, a creditor of the patient/or entitled to any part of his/her estate under a will now existing or by operation of law.

## **Witness #1**

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

## **Witness #2**

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

# APPOINTMENT OF A PATIENT ADVOCATE

I, \_\_\_\_\_ hereby appoint:  
(Print your full name)

\_\_\_\_\_  
(Print patient advocate's name)

as my patient advocate and authorize my patient advocate to make health and personal care decisions for me as stated in this document. I authorize my patient advocate to make a decision to withhold or withdraw treatment, and I acknowledge such a decision could or would allow me to die. Hospice may be considered.

*(Appoint only a person with whom you have talked and whom you trust to understand and carry out your values and wishes).*

## Successor Patient Advocate

I appoint \_\_\_\_\_ as my successor patient advocate and authorize him/her to make health and personal care decisions for me, as stated in this document, if my patient advocate does not accept the appointment, is incapacitated, resigns, is removed by a court, is unwilling or unavailable to act or my patient advocate is my spouse and we become legally separated or divorced.

*(Appoint only a person with whom you have talked and whom you trust to understand and carry out your values and wishes).*

You have the right to revoke or amend this health care power of attorney at any time. If you do so, you should give written notification to your patient advocate, successor patient advocate, physician, hospital and anyone else who may have a copy of the document. You should also provide them with a copy of your most current health care power of attorney.

## Acceptance by patient advocate/successor patient advocate

I agree to be the patient advocate/successor patient advocate for \_\_\_\_\_.

I accept the responsibility and agree to take reasonable steps to follow the desires and instructions of the patient as outlined in this document.

*I understand that:*

- I cannot make a decision to withhold or withdraw care from a patient who is pregnant if that decision would result in the patient's death.
- I cannot receive compensation for this responsibility but may be reimbursed for actual and necessary expenses.
- The patient can revoke my designation as patient advocate at any time and I may revoke my acceptance at any time.
- I can only make decisions consistent with Michigan law.
- I may make a decision to withhold or withdraw treatment which would allow the patient to die only if the patient has expressed in a clear and convincing manner that I am authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.
- I have the responsibility to act as a fiduciary and make decisions consistent with the patient's best interests, which are presumed to be those expressed or evidenced by the patient while able to participate in medical or mental health treatment decisions.
- My authority shall not become effective unless the patient is unable to make medical or mental health treatment decisions, as applicable.
- If authorized by this document to make an anatomical gift, my authority remains exercisable after the patient's death.
- I cannot exercise any powers concerning the patient's care, custody, medical or mental health treatment that the patient could not have exercised for himself/herself.
- A patient admitted to the hospital has the rights enumerated in section 20201 of the Michigan Public Health Code (MCL 333.20201).

### PATIENT ADVOCATE

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

### SUCCESSOR PATIENT ADVOCATE

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_