



## MICHIGAN ADVANCE DIRECTIVE

### **Designation of Patient Advocate Form And Directions for Health Care Durable Power of Attorney for Health Care**

This is an important legal document. You should discuss it with your doctor and attorney if you have questions.

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.

#### **Appointment of Patient Advocate**

I appoint the following person my Patient Advocate:

Patient Advocate's Name \_\_\_\_\_

Address \_\_\_\_\_

#### **Appointment of Successor Patient Advocate(s)**

I appoint the following person(s), in the order listed, my successor Patient Advocate if 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.

Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

My Patient Advocate or successor Patient Advocate may delegate his/her powers to the next successor Patient Advocate if he or she is unable to act.

My Patient Advocate or successor Patient Advocate may only act if I am unable to participate in making decisions regarding my medical treatment.

## Instructions For Care

### 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 health care providers, and arrange to pay them reasonable compensation.
- 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.

### 2. Specific Instructions

My Patient Advocate is to be guided in making medical 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.

#### a. Specific Instructions Regarding Care I Do Want.

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#### b. Specific Instructions Regarding Care I Do Not Want.

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#### c. Specific Instructions Regarding Life Sustaining Treatment

I understand that I do not have to choose one of the instructions regarding life sustaining treatment listed below. If I choose one, I will sign below my choice.

If I sign one of the choices listed below, I direct that reasonable measures be taken to keep me comfortable and relieve pain.

**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:

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**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 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 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:

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 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 \_\_\_\_\_

Name \_\_\_\_\_

(type or print)

Address \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

**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, 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 and that I am at least eighteen years old.

**Witnesses**

Sign Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

Sign Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

**REAFFIRMED**

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

### **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 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 treatment decisions.
- b. A Patient Advocate shall not exercise powers concerning the patient's care, custody, and medical 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 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 Advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.
- i. 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.

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**

Sign Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

**Successor PATIENT ADVOCATE**

Sign Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

**Successor PATIENT ADVOCATE**

Sign Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_