CADILLAC
FAMILY
PHYSICIANS

MAKING YOUR MEDICAL WISHES KNOWN

Advance Medical Directive & Treatment Preferences

8950 PROFESSIONAL DRIVE, CADILLAC, MI 49601
REVISION DATE: 3/10/2017

Overview: Advance Care Planning is a process

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 sudden illness), someone else will have to make those decisions for you. You can choose the person you want to make those decisions – 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 would want.

You should thoughtfully identify your personal values, beliefs, wishes, and treatment goals regarding end of life care. With those values and beliefs in mind, you should then choose your Patient Advocate. Your Patient Advocate needs to learn your treatment goals and values, and be willing to act on your behalf, if and when necessary.

In Michigan, two physicians – or your attending physician and a licensed psychologist – have to examine you and declare that you lack the decision-making ability (also called decision-making capacity) before a Patient Advocate may act on your behalf.

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

- While you may appoint a Patient Advocate and alternate Patient Advocate(s), only one person may act as your Patient Advocate at any given time.
- Your Patient Advocate(s) must sign the form entitled "Accepting the Role of Patient Advocate" (or a similar form) before acting on your behalf.
- Your Patient Advocate may 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.

NOTE: This Advance Directive will replace any Advance Directive you have completed in the past. You may change your mind about your Patient Advocate designation at any time by communicating in any manner that this designation does not reflect your wishes. A written, signed document is recommended, but not required.

PLEASE NOTE:

- *Your Patient Advocate may be a spouse or relative, but it is not required. For some people, a friend, partner, clergy or co-worker might be the right choice.*
- *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 for future medical decision-making.*
- *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 summary, a good Patient Advocate must be able to serve as your voice and honor your wishes.

Instructing Your Patient Advocate

It is important for you to educate and 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 also important for your Patient Advocate to know any particular concerns you have about medical treatment, especially any treatment you would refuse or want stopped. 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 (see: Specific Instructions to My Patient Advocate).*

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:

- Experiences you have had in the past with family or loved ones who were ill;
- Spiritual and religious beliefs, especially those that concern illness and dying;
- Fears or concerns you have about illness, disability or death;
- What gives your life meaning or sustains you when you face serious challenges.

If your Patient Advocate does not know what you would want in a given circumstance, it is his or her duty to decide, in consultation with your medical team, what is in your best interest.

Your Patient Advocate will have your permission to:

- Make choices for you about your 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;
- Interpret any instructions you have given in this form (or in other discussions) according to his or her understanding of your wishes and values;
- Review and release your medical records, mental health records, and personal files as needed for your medical care;
- Arrange for your medical care, treatment and hospitalization in Michigan or any other state, as he or she thinks appropriate or necessary to follow the instructions and directives you have given for your care.

What Now?

Now that you have completed your Advance Directive, you should also take the following steps:

- Tell the person you named as your Patient Advocate, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future. Have your Patient Advocate sign the Patient Advocate form ***as soon as possible!***
- Talk to the rest of your family and/or close friends who might be involved if you have a serious illness or injury. Make sure they know your wishes and the names of your Patient Advocate(s).
- Make sure your wishes are understood and will be followed by your doctor or other health care providers.
- Keep a copy of your Advance Directive where it can be easily found (do NOT place it in a safe deposit box!).
- If you go to a hospital or a nursing home, take a copy of your Advance Directive with you and ask that it be placed in your medical record.

Review your Advance Directive every time you have an annual physical exam or whenever one of the "Five D's" occur:

Decade – when you start each new decade of your life.
Death – whenever you experience the death of a loved one.
Divorce – if you (or your Patient Advocate) experience a divorce or other major family change.
Diagnosis – if you are diagnosed with a serious health condition.
Decline – if you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

Upon your request, a copy will also be sent to any other physician or healthcare facility providing care to you. *Photocopies of this document may be relied upon as though they were originals.*

Please specify where **copies** of this Advance Directive will be **stored** and with whom (in addition to Patient Advocates):

Healthcare Providers:

Contact Name: ______________________________ Phone ______________________

Address: ____

Contact Name: ______________________________ Phone ______________________

Address: ____

(continues on next page)

Hospital System:

Name: ____

Others (e.g. family members, friends, clergy, attorney):

Contact Name: ______________________ Phone ________________

Address: ____

Contact Name: ______________________ Phone ________________

Address: ____

Contact Name: ______________________ Phone ________________

Address: ____

Contact Name: ______________________ Phone ________________

Address: ____

Contact Name: ______________________ Phone ________________

Address: ____

Great Lakes Health Connect:

Date uploaded ____________

MakingChoicesMichigan
Discuss. Decide. Document.

Advance Directive

Durable Power of Attorney for Healthcare
(Patient Advocate Designation)

Introduction

This is a legal document, developed to meet the legal requirements for Michigan. This document provides a way for an individual to create a Durable Power of Attorney for Healthcare (Patient Advocate Designation) and other documentation that will meet the basic requirements for this state.

This **Advance Directive** allows you to appoint a person (and alternates) to make your health care 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*.

It *does not* give your Patient Advocate any authority to make your financial or other business decisions. In addition, it *does not* give your Patient Advocate authority to make certain decisions about your mental health treatment.

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.

If you want to document your views about future health care, but do not want to or cannot use this Advance Directive, ask your health organization or attorney for advice about alternatives.

This is an Advance Directive for:

Name: ______________________ Date of Birth:__________ Last 4 digits of SSN:______

Telephone (Day): ______________ (Evening): ______________ (Cell): ______________

Address: ____

City/State/Zip: ____

Where I would like to receive hospital care (whenever possible): ____________________

Advance Directive: My Patient Advocate

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my Patient Advocate. This person will make my health care decisions when I am determined to be incapable of making health care decisions under Michigan law. I understand that it is important to have ongoing discussions with my Patient Advocate about my health and health care choices.

I hereby give my Patient Advocate permission to send a copy of this document to other doctors, hospitals and health care providers that provide my medical care.

My Patient Advocate may make medical treatment decisions on my behalf only if I am unable to participate in my own medical treatment decisions.

(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.* ***It is recommended that you complete a new Advance Directive and give it to everyone who has a previous copy.)

The person I choose as my Patient Advocate is

Name: ______________________ Relationship (if any):__________

Telephone (Day): ____________ (Evening): ____________(Cell): ____________

Address: ____

City/State/Zip Code: ______________________________________

First Alternate Patient Advocate (strongly advised)

If Patient Advocate above is not able or willing to make these choices for me, ***OR*** *is divorced or legally separated from me, then I designate the following person to serve as my Patient Advocate.*

Name: ______________________ Relationship (if any):__________

Telephone (Day): ____________ (Evening): ____________(Cell): ____________

Address: ____

City/State/Zip Code: ______________________________________

Second Alternate Patient Advocate (strongly advised)

If the Patient Advocates named above are not able or willing to make these choices for me, ***OR*** *is divorced or legally separated from me, then I designate the following person to serve as my Patient Advocate.*

Name: ______________________ Relationship (if any):__________

Telephone (Day): ____________ (Evening): ____________(Cell): ____________

Address: ____

City/State/Zip Code: ______________________________________

Advance Directive Signature Page

I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life-sustaining treatment - such as, but not limited to: ventilator (breathing machine), cardiopulmonary resuscitation (CPR), nutritional tube feedings, intravenous hydration, kidney dialysis, blood pressure or antibiotic medications — and hereby give my Patient Advocate(s) express permission to withhold or withdraw any treatment that would not help me achieve my goals of care. I understand that such decisions could or would allow my death. ***Medications and treatment intended to provide comfort or pain relief shall not be withheld or withdrawn.***

Signature of the Individual in the Presence of the Following Witnesses

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 eighteen (18) years old and of sound mind.

Signature: ______________________________ Date: __________

Address: ______________________________

City/State/Zip Code: ______________________________

Signatures of Witnesses

I know this person to be the individual identified as the "Individual" signing this form. I believe him or her to be of sound mind and at least eighteen (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 or alternate Patient Advocate appointed by the person signing this document.
- Not the patient's spouse, parent, child, grandchild, sibling or presumptive heir.
- Not listed to be a beneficiary of, or entitled to, any gift from the patient's estate.
- Not directly financially responsible for the patient's health care.
- Not a health care provider directly serving the patient at this time.
- Not an employee of a health care or insurance provider directly serving the patient at this time.

Witness Number 1:

Signature: ______________________________ Date: __________

Print Name: ______________________________

Address: ______________________________

City/State/Zip Code: ______________________________

Witness Number 2:

Signature: ______________________________ Date: __________

Print Name: ______________________________

Address: ______________________________

City/State/Zip Code: ______________________________

Accepting the Role of Patient Advocate

Person completing Advance Directive:

Print Name: ______________________________ Date of Birth:__________________

Acceptance

The person named above has asked you to serve as his or her Patient Advocate (or as an alternate Patient Advocate). Before agreeing to accept the Patient Advocate responsibility and signing this form, please:

1. *Read the **Introduction** and **Overview**, which provide important information and instructions.*
2. *Carefully read this completed form and;*
3. *Discuss, in detail, the person's values and wishes, so that you can gain the knowledge you need to allow you to make the medical treatment decisions he or she would make, if able.*
4. *If you are willing to accept the role of Patient Advocate, read, sign and date the following statement.*

I accept the person's selection of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the person as indicated within this "Advance Directive: My Patient Advocate" document or in other written or spoken instructions from the person. I also understand and agree that, according to Michigan law:

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 understand 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, (Exercise of Rights by Patient's Representative 1978 PA 368, MCL 333.20201).

Accepting the Role of Patient Advocate *(continued)*
Patient Advocate Signature and Contact Information

Signature: ______________________________ Date: ____________

Print Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone (Day): ____________ (Evening): ____________ (Cell): ____________

If I am unable or unavailable to act after reasonable efforts to contact me, I delegate my authority to the person designated as the second choice Patient Advocate. The following Patient Advocates are authorized (in the order listed) to act until I become available to act.

First Alternate Patient Advocate (Optional)

Signature: ______________________________ Date: ____________

Print Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone (Day): ____________ (Evening): ____________ (Cell): ____________

Second Alternate Patient Advocate (Optional)

Signature: ______________________________ Date: ____________

Print Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone (Day): ____________ (Evening): ____________ (Cell): ____________

Making Changes

If only the contact information for your advocate(s) changes, it may be revised on the original and on the photocopies without replacing the entire form.

Photocopies of this form can be made and can be accepted as originals.

If I am nearing end of life...

(This section is optional, but recommended)

SPIRITUAL/RELIGIOUS PREFERENCES

If I am nearing my death, I would like these things for support and comfort:

____

____

____

If I am dying, I would like to be: (check one)

☐ at home ☐ in a hospital ☐ not sure

I am of the __________________ faith and/or consider myself ________________.

I am a member of the __________________________________ faith community.
Please attempt to notify them at ______________________ .

I want my health care providers to know these things about my religion or spirituality:

____

____

____

____

____

My other wishes:

____

____

____

____

____

____ ***I choose not to complete this section***

PREFERENCES FOR ORGAN/TISSUE DONATION, AUTOPSY, ANATOMICAL GIFT AND BURIAL/CREMATION

In this section, you may, if you wish, state your instructions for: organ/tissue donation, autopsy, anatomical gift, and burial or cremation.

By Michigan law, your Patient Advocate and your family must honor your instructions pertaining to organ donation following your death.

The authority granted by me to my Patient Advocate in regard to organ/tissue donation shall, in compliance with Michigan law, remain in effect and be honored following my death.

I understand that whole-body anatomical gift donation generally requires pre-planning and pre-acceptance by the receiving institution.

Burial or cremation preferences reflect my current values and wishes.

Instructions:

- *Put your initials next to the choice you prefer for each situation below.*
- *Cross out the choices you do not want.*

DONATION OF MY ORGANS OR TISSUE (ANATOMICAL GIFTS)

____ After I die, I wish to donate any parts of my body that may be helpful to others.

____ I have indicated this choice on my driver's license or state-issued identification card.

____ I am registered on my state's online donor registry.

____ After I die, I wish to donate ***only the following*** organs or tissue, if possible: (name the specific organs or tissue):________________________________

____

____

____ I ***do not want*** to donate any organ or tissue.

____ ***I choose not to complete this section***

PREFERENCES FOR ORGAN/TISSUE DONATION, AUTOPSY, ANATOMICAL GIFT AND BURIAL/CREMATION

(Continued)

Instructions:

- *Put your initials next to the choice you prefer for each situation below.*
- *Cross out the choices you do not want.*
- *NOTE: Elective autopsy may be at family's expense.*

AUTOPSY, ANATOMICAL GIFT, AND BURIAL/CREMATION PREFERENCE

_____ 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.

_____ I ***want*** my body to be donated to an institution of medical science for research or training purposes.

_____ I ***do not want*** an autopsy performed on me.

My burial or cremation preference is: (initial only one)

____ Burial ____ Cremation

____ Burial or Cremation, at the discretion of my next-of-kin

____ ***I choose not to complete this section***

Great Lakes Health Connect (optional):

Great Lakes Health Connect is a Health Information Exchange providing State-wide internet medical record storage service to medical providers only. There is no cost to you for this service. Making Choices Michigan, your physician or attorney can file it for you. Not all hospitals are accessing this medical storage service at this time. It is recommended that you take a copy of this document with you to the hospital.

I consent to have my Advance Directive stored with Great Lakes Health Connect.

____

Signature/Date

Treatment Preferences (Goals of Care)

(This section is optional, but recommended)

Print Name: ____ Date of Birth:______________________

Specific Instructions to my Patient Advocate -

When I am not able to decide or speak for myself, the following are my specific preferences and values concerning my health care:

Instructions:

- *Put your initials next to the choice you prefer for each situation below.*
- *Cross out the choices you do not want.*

TREATMENTS TO PROLONG MY LIFE

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, where I am, and I am unable to meaningfully interact with others:

____ I want all possible efforts to prolong life made on my behalf, even if it means I may remain on life-sustaining equipment, such as a breathing machine or kidney dialysis, for the rest of my life.

OR

____ I want my health care providers to try treatments to prolong my life for a period of time. However, I want to stop these treatments if they do not help, or if they cause me pain and suffering.

OR

____ I want to stop or withhold all treatments to prolong my life.

In all situations, I want to receive treatment and care to keep me comfortable.

____ ***I choose not to complete this section***

Instructions:

- *Put your initials next to the choice you prefer for each situation below.*
- *Cross out the choices you do not want.*

CARDIOPULMONARY RESUSCITATION (CPR)

If my heart or breathing stops:

____ I **want** CPR in all cases.

OR

____ I **want** CPR unless my health care providers determine that I have any of the following:

- An injury or illness that cannot be cured and I am dying.
- No reasonable chance of surviving if my heart or breathing stops.
- Little chance of surviving long term if my heart or breathing stops and it would be hard and painful for me to recover from CPR.

OR

____ I ***do not want*** CPR but instead want to allow natural death.

Additional Specific Instructions

I want my Patient Advocate to follow these specific instructions, which may limit the authority previously described in General Instructions to My Patient Advocate.

____

____

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____ ***I choose not to complete this section***

Treatment Preferences (Goals of Care) Signature Page

(If you are satisfied with your choice of Patient Advocate and with the Treatment Preferences guidance you have provided in this Section, you need to sign and date the statement below.)

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 eighteen (18) years old and of sound mind. These are my preferences and goals expressed and affirmed on the date below:

Signature: ______________________________________ Date: ____________

MakingChoicesMichigan
Discuss. Decide. Document.

Wallet Card

NOTICE: I have an Advance Directive

Name:____________________________

My Patient Advocate: ____________________

My Patient Advocate's phone number: __________

A copy of my Advance Directive can be found at:

____

Specific instructions:___________________

____

____

My physician's name:___________________

My physician's phone number: ______________

Signature/Date:

NOTICE: I have an Advance Directive

Name:____________________________

My Patient Advocate: ____________________

My Patient Advocate's phone number: __________

A copy of my Advance Directive can be found at:

____

Specific instructions:___________________

____

____

My physician's name:___________________

My physician's phone number: ______________

Signature/Date:

*This **Wallet Card** template is the same size as a credit card.*
Fill in your information, then photocopy this page, fold two-sided and tape or glue.

CADILLAC
FAMILY
PHYSICIANS

8950 PROFESSIONAL DRIVE
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Our Care Management Team is available to explain topics covered and assist you with completing this document.

Please call (231) 775-2493

A copy of this document will be shared with Munson Healthcare