DESIGNATION OF PATIENT ADVOCATE FORM

AND DIRECTIONS for HEALTH CARE

(Durable Power of Attorney for Health Care)

NAME: ______________________________ DOB: ___________________

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

MidMichigan
Health

Here you name someone to act for you regarding your care, custody and treatment. This person is called a "Patient Advocate." You may name anyone who is at least eighteen years old and of sound mind. You may also name one or more persons to act if your first choice cannot.

If you change your mind, you may revoke your appointment of a Patient Advocate at any time.

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 ______________________________
type or print

Address ______________________________

Telephone (h) ____________ (w) ____________ (c) ____________

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 ______________________________

Telephone (h) ____________ (w) ____________ (c) ____________

Name ______________________________
type or print

Address ______________________________

Telephone (h) ____________ (w) ____________ (c) ____________

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, or as applicable, mental health treatment.

This section gives instructions for your care. Cross out and initial any instructions you do not want.

Under instruction 1.b., your Patient Advocate has the right to make arrangements for your care but is not required personally to pay the cost of your care.

Note: Current law does not permit your Patient Advocate to make decisions to withhold or withdraw treatment if you are pregnant, if that decision would result in your death, to engage in homicide or euthanasia, or to force medical treatment you do not want because of your religious beliefs.

You may list specific care and treatment you do or do not want. Otherwise, your general instructions will stand for your wishes.

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 mental health treatment including, but not limited to the following:

a. Have access to, obtain copies of and authorize release of my medical, mental health and other personal information.

b. Employ and discharge physicians, nurses, therapists, any other health care providers, mental health professionals and other providers, and arrange to pay them reasonable compensation.

c. Consent to, refuse or withdraw for me any medical or mental health 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 and mental health 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.

____

____

____

b. Specific Instructions Regarding Care I DO NOT Want.

____

____

You do not have to choose one of the specific instructions about life sustaining treatment in this section. But if you do, sign only one instruction.

You should discuss these choices with your doctor.

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: Regardless of my condition, I do not want life-sustaining treatment initiated. I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here: ___________________________________

Choice 2: If I have an end-stage illness or irreversible condition, I do not want life-sustaining treatment initiated.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here: ___________________________________

Choice 3: If I have an end-stage illness or irreversible condition, I want my life to be prolonged by life-sustaining treatment until it is determined by my physician that medical intervention is futile. At that time, I want all life-sustaining treatment discontinued.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here: ___________________________________

Choice 4: 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:

____

____

____

e. Specific Instructions Regarding Anatomical Gifts (Optional)

My Patient Advocate has the authority, upon or immediately before my death, to make an anatomical gift of all or a part of my body for therapy or transplantation needed by another individual; for medical or dental education, research or the advancement of medical or dental science; or for any other purpose permitted by law. This authority granted to my Patient Advocate shall remain exercisable following my death.

If this statement reflects your desires, sign here:

____

Patient's Signature

f. Specific Instructions Regarding Mental Health Treatment

I understand that I may, but am not required, to designate a physician, mental health practitioner, or both, to certify, in writing and after examining me, that I am unable to give informed consent to mental health treatment. If any physician or mental health practitioner whom I designate is unable or unwilling to conduct the examination and to make this determination within a reasonable time, I understand that another physician or mental health practitioner, as applicable, shall make the examination and determination.

I designate the following physician(s) and/or mental health practitioner(s) for this purpose *(no designation is made if left blank):*

____

Name of Physician(s) and/or Mental Health Practitioner(s)

With regard to mental health treatment decisions, my Patient Advocate is authorized to consent to the forced administration of medication, or to inpatient hospitalization (other than hospitalization as a formal voluntary patient as provided by law) only if I have authorized the Patient Advocate to do so by signing immediately below. I understand that if I am hospitalized as a formal voluntary patient under an application executed by my Patient Advocate, I retain the right to terminate the hospitalization as provided by law:
If you give the consent described above, sign here: ______________________

I understand that I may revoke my Patient Advocate designation at any time and in any manner sufficient to communicate intent to revoke. However, I may choose to waive my right to revoke my Patient Advocate designation as to the power to exercise mental health treatment decisions by making this waiver as part of my designation document. If I waive this right to revoke, I understand that mental health treatment provided to me shall not continue for more than 30 consecutive days, and that the waiver does not affect my rights under section 419 of the Mental Health Code, 1974 PA 258, MCL 330.1419, or as it may be amended or superseded by another statute.

*If you waive your right to revoke your Patient Advocate designation as to the power to exercise mental health treatment decisions, sign here:*______________________

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 where 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.

Sign and date below in the presence of at least two witnesses who meet the requirements listed in the witness statement on the following page.

Signature

Sign Name ____________________________ Date ____________________

Name ____
type or print

Address ____

Witness Statement And Signature

If the witness does not personally know the person who is signing this Designation, the witness should ask for identification, such as a driver's license.

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 ______________________	Sign Name ______________________
Name ______________________ (type or print)	Name ______________________ (type or print)
Address ______________________	Address ______________________
______________________	______________________
Date ______________________	Date ______________________

You should review this document from time to time and when there is a change in your health or family status. When you review it, if it still expresses your intent, sign and date under the Reaffirmed section below to show you still agree with its contents. If your wishes change, destroy this document, make out a new one and give a copy to everyone who has a copy of the old version.

You should discuss this document with the person you want to have as your Patient Advocate and have him/her sign the Acceptance of Patient Advocate on the next page.

REAFFIRMED

Date ______________________	Signature ______________________
Date ______________________	Signature ______________________
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 as determined by two physicians or one physician and a licensed psychologist.

b. A Patient Advocate shall not exercise powers concerning the patient's care, custody, and 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. 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 or mental health 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 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.

Keep the signed original with your personal papers at home.

i. 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.

j. A Patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, 1978 PA 368, MCL333.20201.

k. If the designation authorizes the Patient Advocate to make an anatomical gift, the authority remains exercisable after the Patient's death. A Patient Advocate may not exercise the authority to make an anatomical gift if the Patient Advocate has received actual notice that the Patient expressed an unwillingness to make the gift.

These restrictions are required by the Patient Advocate Act of 1990, P.A. No. 312. (MCLA 700.496)

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______________________________
type or print

Successor PATIENT ADVOCATE

Sign Name ______________________________

Name______________________________
type or print

Successor PATIENT ADVOCATE

Sign Name ______________________________

Name______________________________
type or print

Copies of this document should be given to all advocates, your physician, and the hospitals where you receive care.

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