

**Person Appointing Patient Advocate:**

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

Date of Birth \_\_\_\_\_

Date signed \_\_\_\_\_

Phone contact(s) \_\_\_\_\_

# Making Choices Michigan



## **Advance Care Planning:**

Planning for Future Health Care Decisions

## **Advance Directive:**

Durable Power of Attorney for Healthcare

## **Forms Included:**

Choosing My Patient Advocate

Accepting the Role of Patient Advocate

**Keep this document for your records and make copies  
for Patient Advocates and healthcare providers.**

# **A Brief Guide to Advance Care Planning**

Thank you for taking the time to learn about patient advocacy and advance care planning.

**There are two major roles:**

- Patient
- Patient Advocate

Both roles are important. The patient must thoughtfully identify his or 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 to Advance Care Planning”**: This provides an overview of the process and instructions for completing the two forms. We strongly suggest that both the Patient and the Patient Advocate read this guide and discuss it with each other.
2. **Form 1: “Choosing My Patient Advocate”**: This is the form the Patient will complete to name and provide instructions for the Patient Advocate.
3. **Form 2: “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 (also called an Advance Directive or a Durable Power of Attorney for Healthcare) allows you to identify the patient advocate you have chosen. It also instructs your patient advocate concerning your values or wishes, so he or she can act appropriately on your behalf, should they be called upon to do so.

It is important for both you and your patient advocate to understand that your patient advocate may make decisions for you only when you lack the ability to do so.

In Michigan, two physicians, including your attending physician and another doctor or 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 “Form 2: Accepting the Role of Patient Advocate” (or a similar form) before acting on your behalf.
- 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 Form 1:

# Choosing My Patient Advocate

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## Section 1: Naming your Patient Advocate

In this section you will name your patient advocate. You may also name one or more alternate patient advocates in the event your first choice for patient advocate is unavailable or 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, 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.
- 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.

## Section 2: Instructing your Patient Advocate

In this section, 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 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 (Section 2, part B).

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.

### **Section 3: Your Wishes Following Death**

#### **Organ Donation, Autopsy, Donation of Anatomical Gift and Burial–Cremation Preferences**

In this section, you may, if you wish, state your instructions for organ/tissue donation, autopsy, anatomical gift, and burial or cremation. By law, instructions pertaining to organ donation must be honored by your patient advocate and your family following your death.

### **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, presumptive heir, physician or employee of your current physician, healthcare facility, or insurance carrier. 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 Choosing My Patient Advocate form and they believe you to be of sound mind and under no duress, fraud, or undue influence.

You are also encouraged to give a photocopy to your:

- primary care physician,
- preferred hospital(s), or
- other health care providers.

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.

# Form 1

## Choosing My Patient Advocate

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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 my patient advocate permission to send a copy of this document to other doctors, hospitals and health care providers that provide medical care to me. My patient advocate may make medical treatment decisions on my behalf only if I am unable to participate in my own medical treatment decisions.

### Section 1: Naming My Patient Advocate

I, (print your name) \_\_\_\_\_,  
choose the person named below to be my patient advocate.

Patient Advocate Name: (print) \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

#### Naming Alternate Patient Advocates (Optional)

If the individual named above as my patient advocate is unable, unwilling or unavailable to serve as my patient advocate, then I designate the following to serve as my first alternate patient advocate.

First Alternate Patient Advocate: (print) \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

If the patient advocate and first alternate patient advocate named above are unable, unwilling or unavailable to serve as my patient advocate, then I designate the following to serve as my second alternate patient advocate.

Second Alternate Patient Advocate: (print) \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

## Section 2: Instructing My Patient Advocate

### A. General Instructions

I want my patient advocate to be able to:

- Make choices for me about 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;
- 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 or she thinks appropriate or necessary to follow the instructions and directives I have given for my care.

### B. Specific Instructions (Optional)

#### Life-Sustaining Treatment

*Also see "Form 2 - Accepting the Role of Patient Advocate, line d. If this is your directive, please sign below.*

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, ventilators, cardiopulmonary resuscitation, 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.

**My signature authorizing this specific directive:**

\_\_\_\_\_



### Other Specific Instructions

I want my patient advocate to follow these specific instructions, which may limit the authority previously described in Section 2.

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### Section 3: My Wishes following Death (Optional)

#### Organ/Tissue Donation, Autopsy, Anatomical Gift and Burial–Cremation preference

Below are the instructions I wish to be followed by my patient advocate after my 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 a medical institution. Burial or cremation preferences reflect my current values and wishes.

#### A. Organ or Tissue Donation for Transplantation (please initial your choice)

\_\_\_\_\_ I wish to donate any organs or tissue, if I am a candidate.

\_\_\_\_\_ I wish to donate only the following organs or tissue, if I am a candidate:  
(name or check the specific organs or tissue):

Specific organs: \_\_\_\_\_

Specific Tissue:

Corneas \_\_\_\_\_ Skin \_\_\_\_\_ Bone \_\_\_\_\_ Heart valves \_\_\_\_\_

Nerves \_\_\_\_\_ Tendons \_\_\_\_\_ Veins \_\_\_\_\_

\_\_\_\_\_ I do not want to donate any organ or tissue.

## B. Autopsy, Anatomical Gift, and Burial–Cremation Preference

*Initial the statement or statements that reflect your wishes and draw a line through the statements that you do not want.*

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

\_\_\_\_\_ 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 wish my body to be donated to an institution of medical science for research or training purposes.

My burial or cremation preference is: (check one) Burial \_\_\_\_\_ Cremation \_\_\_\_\_

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

## Section 4: Signing the Patient Advocate Form and Having it Witnessed

### Signature of the Patient 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: \_\_\_\_\_

### Signatures of the Witnesses

I know this person to be the individual identified as the “patient” in the “Choosing My Patient Advocate” 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: \_\_\_\_\_

Witness number 2:

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

Print Name: \_\_\_\_\_

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

## Instructions for Form 2:

# Accepting the Role of Patient Advocate

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Under Michigan law, your patient advocate (or alternate patient advocate) cannot act on your behalf until he or she receives a copy of your “Choosing My Patient Advocate” form and accepts the role of patient advocate in writing. Your patient advocate (and any alternate patient advocate) must read, sign and date the statements contained in “Accepting the Role of Patient Advocate.” The patient advocate signature does not need to be witnessed or notarized.

You should provide your patient advocate with:

- a copy of this “Brief Guide to Advance Care Planning”;
- a completed copy of “Form 1: Choosing My Patient Advocate”; and
- Form 2: “Accepting the Role of Patient Advocate.”

# Form 2

## Accepting the Role of Patient Advocate

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Patient Name: (print) \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

The person named above has asked you to serve as his or her patient advocate (or as an alternate patient advocate). Before agreeing to take on that responsibility and signing this form, please:

1. Read a copy of the form the patient has completed entitled, Form 1: "Choosing My Patient Advocate", and;
2. Read the document entitled, "A Brief Guide to Advance Care Planning," which provides important information and instructions.
3. Discuss, in detail, the patient'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 want.
4. If you are willing to accept the role of patient advocate, read, sign and date the following statement (Section 5).

### Acceptance

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, 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, 1978 PA 368, MCL 333.20201.

## Section 5: Patient Advocate Signature and Contact Information

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

Print Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the person the patient has designated as the alternate patient advocate. The alternate patient advocate is authorized (in the order listed) to act until I become available to act.

**Alternate Patient Advocates(s) (Optional)**

First Alternate Patient Advocate

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

Print Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Second Alternate Patient Advocate

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

Print Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

**Making Changes**

If the names of your patient advocate(s) or your specific directives to them change (Section 2 or 3), you will need to collect and destroy the original and all photocopies and re-distribute a new “Choosing My Patient Advocate” form and “Accepting the Role of Patient Advocate” form.

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.

