INSTRUCTIONS

MICHIGAN
DESIGNATION OF PATIENT ADVOCATE FOR HEALTH CARE

PRINT YOUR NAME AND ADDRESS

I _____
(name)

_____
(address)

am of sound mind, and I voluntarily make this designation.

PRINT THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR PATIENT ADVOCATE

I designate _____
(name of patient advocate)

residing at _____
(address)

_____
(home phone number) *(work phone number)*

as my patient advocate to make care, custody, or medical treatment decisions for me only when I become unable to participate in medical treatment decisions. The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

If the first individual is unable, unwilling, or unavailable to serve as my patient advocate, then I designate:

PRINT THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR ALTERNATE PATIENT ADVOCATE

_____
(name of successor agent)

residing at _____
(address)

_____
(home phone number) *(work phone number)*

to serve as my patient advocate.

I authorize my patient advocate to decide to withhold or withdraw medical treatment which could or would allow me to die. I am fully aware that such a decision could or would lead to my death.

In making decisions for me, my patient advocate shall be guided by my wishes, whether expressed orally, in a living will, or in this designation. If my wishes as to a particular situation have not been expressed, my patient advocate shall be guided by his or her best judgment of my probable decision, given the benefits, burdens and consequences of the decision, even if my death, or the chance of my death, is one consequence.

My patient advocate shall have the same authority to make care, custody and medical treatment decisions as I would if I had the capacity to make them EXCEPT *(here list the limitations, if any, you wish to place on your patient advocate's authority)*:

LIST LIMITATIONS TO YOUR PATIENT ADVOCATE'S AUTHORITY (IF ANY)

This designation of patient advocate shall not be affected by my disability or incapacity. This designation of patient advocate is governed by Michigan law, although I request that it be honored in any state in which I may be found. I reserve the power to revoke this designation at any time by communicating my intent to revoke it in any manner in which I am able to communicate.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I voluntarily sign this designation of patient advocate after careful consideration. I accept its meaning and I accept its consequences.

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR ADDRESS

_____ _____
(your signature) *(date)*

_____
(your street address)

_____
(city, Michigan, zip code)

WITNESSING PROCEDURE

WITNESSES MUST SIGN AND PRINT THEIR NAME AND ADDRESS

Statement of Witnesses

We sign below as witnesses. This designation was signed in our presence. The designator appears to be of sound mind, and to be making this designation voluntarily, and under no duress, fraud, or undue influence.

Witness 1: _____
(signature)

_____
(print or type full name)

_____
(address)

Witness 2: _____
(signature)

_____
(print or type full name)

_____
(address)

ACCEPTANCE STATEMENT

Acceptance by Patient Advocate and Successor Advocate (If Any)

(A) This designation shall not become effective unless the patient is unable to participate in 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 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 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.

(J) A patient advocate may choose to have the patient placed under hospice care.

YOUR PATIENT ADVOCATE MUST SIGN AND DATE YOUR DOCUMENT HERE

I understand the above conditions and I accept the designation as patient advocate for _____.
(name of principal)

Dated _____ Signed _____

YOUR ALTERNATE PATIENT ADVOCATE MUST SIGN AND DATE YOUR DOCUMENT HERE

I understand the above conditions and I accept the designation of successor patient advocate for _____.
(name of principal)

Dated _____ Signed _____

INSTRUCTIONS

PARTNERSHIP FOR CARING
LIVING WILL

PRINT YOUR NAME

I, _____,
being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally required to be specific about future treatments, if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:

CROSS OUT ANY STATEMENTS THAT DO NOT REFLECT YOUR WISHES

I do not want cardiac resuscitation.
I do not want mechanical respiration.
I do not want tube feeding.
I do not want antibiotics.

However, I do want maximum pain relief, even if it may hasten my death.

ADD PERSONAL INSTRUCTIONS (IF ANY)

Other directions (insert personal instructions):

These directions express my legal right to refuse treatment under federal and state law. I intend my instructions to be carried out, unless I have revoked them in a new writing or by clearly indicating that I have changed my mind.

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

Signed: _____ Date:_____

Address: _____

_____

WITNESSING PROCEDURE

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness: _____

Address: _____

_____

Witness: _____

Address: _____

_____

Courtesy of Partnership for Caring, Inc. 4/00
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