A Guide to Completing Your Designation of Patient Advocate Form

HONORING
Healthcare Choices

An Advance Care Planning Program of MidMichigan Health and its Community Partners

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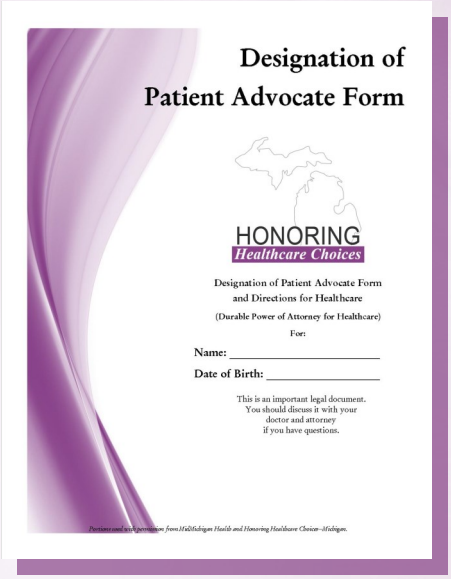
This workbook is designed to accompany the coordinating Designation of Patient Advocate Form to help you organize your feelings and priorities regarding your future healthcare options. **This workbook also contains specific instructions that will help guide you through completing the Designation of Patient Advocate form. Please read through this workbook in its entirety prior to attempting to fill out the Designation of Patient Advocate form.**



As you look through this workbook, please note that content printed in the **purple font** used in this paragraph is supplemental information or instructions to help you with the actual form.

Content printed in the **black font** used in this paragraph is content taken directly from the Designation of Patient Advocate Form and can be used as a practice form while you are determining what information you would like to have in your final document.

If you have questions or need help with this workbook or the Designation of Patient Advocate Form, please contact MidMichigan Health's Advance Care Planning Department at (989) 839-3167.

What is Advance Care Planning?

Advance Care Planning is a process of conversation that helps you determine what medical treatments you would want in an unexpected event, and who would speak on your behalf if you were unable to speak for yourself.

No one likes to think about it, but a time may come when we can't make important health care decisions for ourselves. Things such as unexpected brain injury or diseases like Alzheimer's or Parkinson's can make it impossible for you to understand your medical options. If something like this should happen, who will speak for you? Who will know what you would have wanted? Who will carry out your wishes?

An Advance Directive for Health Care is a legal document that allows you to choose a "Patient Advocate." This document may also be called a Designation of Patient Advocate Form or Designation of Durable Power of Attorney for Healthcare. The person that you choose to identify as your Patient Advocate in this document should be a person you trust. It should be someone you would want to speak for you and make medical decisions for you if you become permanently or temporarily unable to make your own decisions.

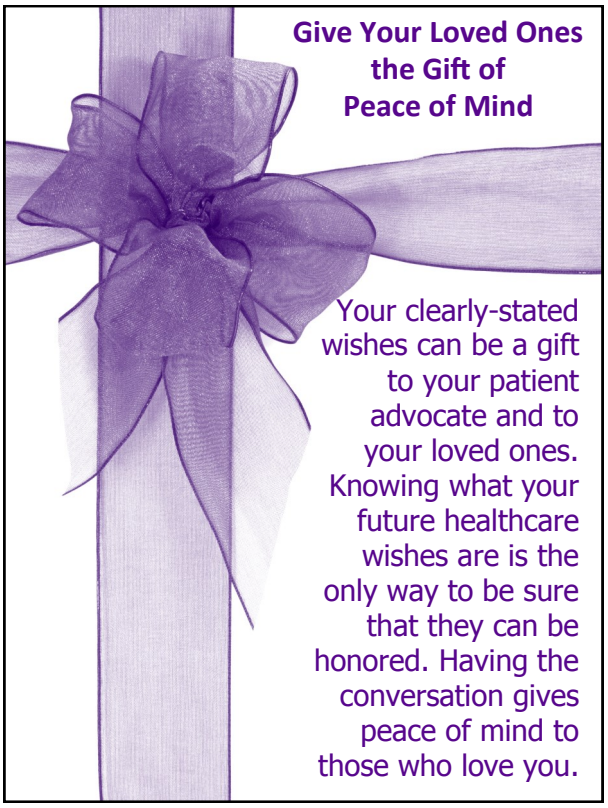
The Designation of Patient Advocate Form also serves another important purpose; it helps you clearly express your views so that your Patient Advocate(s) and your physician(s) know what medical treatments you would – and would not – want in a future medical crisis.

It is important to understand that a Designation of Patient Advocate Form will only be used in situations when you are not able to make your own decisions. No one can make decisions for you if you are still able to make those decisions and speak for yourself.

A Gift For Your Loved Ones

If you don't choose a Patient Advocate or complete an Advance Directive form, it can be very difficult for your loved ones to try to guess what you would want in a medical crisis. Think of an Advance Directive as a gift to your loved ones as well as a way of making sure that you always have a say in your own medical care.

Everyone 18 years of age and older should complete a Designation of Patient Advocate Form. A serious illness or injury can happen at any time. It's best to be prepared. You can always change your mind about the details of your document, and as long as you are still able to make your own medical decisions, you can name a new Patient Advocate by completing another document.



Choosing Your Patient Advocate

The naming of your Patient Advocate and Successor Patient Advocates, found on **page 3** of your Designation of Patient Advocate Form, is a crucial section of your document. Choosing your Patient Advocate(s) is one of the most important parts of your advance care planning efforts. Your Patient Advocate will enforce the decisions you have already made about your healthcare in the future, should you ever be unable to make decisions for yourself. Your Patient Advocate may also have to make decisions in matters you have not discussed, therefore, your Patient Advocate needs to be someone that you truly trust with your life.

When thinking about choosing your Patient Advocate, be willing to think beyond the obvious members of your immediate family or your spouse. Sometimes these people are the best choice, but sometimes, they are not. As all families and all relationships are different, so are the circumstances that will determine who is most qualified to make your healthcare decisions in the future if you are ever unable to speak for yourself. Keep the following in mind.

Your Patient Advocate:

- Must be at least 18 years of age and of sound mind.
- Should be someone who will be able to honor your wishes no matter how difficult the situation.
- **Cannot** be your physician, your medical or mental health professional, or any other professional providing care to you.
- Must be someone who will discuss your wishes with you and sign a form accepting the responsibility to speak on your behalf if you become unable to speak for yourself.
- May be unable or unwilling to act as your Patient Advocate at some point in the future. To be prepared for this, you should choose a "Successor Patient Advocate" in the event that your first Patient Advocate is not able or willing to fulfill his or her responsibilities. Your Successor Patient Advocate must also sign a form accepting the responsibility of speaking on your behalf in the future if you are unable to speak for yourself.
- Can always change his or her mind about being your advocate.

Please note that your Patient Advocate(s) phone numbers *must* be listed with their name. Your Patient Advocate(s) can only help you if your medical team is able to reach them.

IMPORTANT FACTS ABOUT YOUR PATIENT ADVOCATE'S POWER

You can always change your mind and revoke the person who is appointed as your Patient Advocate.

Your Patient Advocate will never have the right to speak on your behalf unless two physicians, or one physician and one licensed psychologist have determined, in writing, that you are unable to participate in your own healthcare decisions.

If it is determined that you cannot make your own medical decisions, but you later regain your ability to speak for yourself, your advocate will no longer have the right to speak on your behalf. Additionally, the determination that you can no longer make your own healthcare decisions must be revisited annually, regardless of whether or not any improvement in your condition is expected.

Deciding What's Best for You: What do You Value? What do You Believe?

The next few pages of this workbook are designed to help you think about what matters the most to you. This is the first step toward deciding what medical care you would want in a life-threatening situation or medical crisis. Once you know what makes you happy to be alive, ask yourself if there are limitations or conditions that would make your life no longer meaningful. Answering the following questions can help you clarify your feelings. But, don't forget that your feelings may change with age, changes in your health, and other life events, so take time to think about these things periodically.

Your Beliefs:

- What roles do pain and suffering have in life?
- Do you believe medical treatment should prolong life?
- When do you believe life stops?

Your Quality of Life:

- What do you fear most about being ill or seriously injured?
- How important is it for you to be physically, mentally, or financially independent?
- How would you feel if you could no longer do the activities you most enjoy?
- How would you feel about being moved from your present home?
- How would you feel about being cared for in a hospital or nursing home at the end of your life?

EXERCISE: Understanding What You Value:

Check the box that best expresses how important you think it is to be able to do the following, then ask yourself if you are able to see what your priorities might be in a medical crisis or illness:

Importance	Very	Somewhat	Not Very
1. Care for myself without being a burden to others.			
2. Get out of bed every day.			
3. Go out on my own.			
4. Recognize my family and friends.			
5. Talk to and understand others.			
6. Make decisions for myself.			
7. Remain in my home as long as I live.			
8. Live without constant or severe pain.			
9. Live without being dependent on medical treatment or machines to keep me alive.			
10. Be financially independent.			
11. Leave money to my family or a cause I believe in.			
12. Be faithful to my beliefs.			
13. Live as long as possible.			
14. Receive all medical treatment possible.			
15. Die naturally, without lingering.			

Treatments You Can Choose or Refuse

Medical treatment at the end of your life generally falls into three main categories: **life-supporting**, **life-sustaining**, and **life-enhancing**. You usually can choose or refuse these treatments at any time. In most cases, you can also try a treatment and then stop it if you don't regain the quality of life you want. Read the following graph and ask yourself which of these treatments agrees with your beliefs and goals for your future healthcare and lifestyle.

Life-Supporting	Life-Sustaining	Life-Enhancing
Life support uses Cardiopulmonary Resuscitation (CPR) and machines to keep your heart and lungs going when they can no longer work on their own.	Life-sustaining care involves treatment and machines to prolong your life when your condition can't be reversed or cured.	Life-enhancing care keeps you comfortable until death occurs naturally. Nothing is done artificially to prolong your life.
CPR restarts your heart and lungs after your heart stops beating. After successful CPR, you are usually transferred to a hospital's intensive care unit (ICU), where you may be put on a mechanical ventilator.	**Tube feeding** provides food and fluids through a tube or IV if you cannot chew or swallow. Tube feeding can help keep you alive indefinitely; without it your body will eventually shut down.	**"Comfort Measures Only" and hospice care** focus on keeping you comfortable as your condition progresses. Palliative care experts can help you remain comfortable and keep you from returning to the hospital if this is your desire.
A mechanical ventilator pumps oxygen into your lungs through a tube inserted in your windpipe. In some cases, normal breathing can never be restored.	**Kidney dialysis** cleans your blood by machine when your kidneys no longer work. Dialysis can prolong your life but cannot restore kidney function.	**Pain medications**, such as morphine and others, can be given to keep you comfortable. Anti-anxiety medications and practical interventions such as fans, fresh air and warm blankets can also be parts of Comfort Measures Only.

Do Not Resuscitate (DNR)

If you are a patient in a hospital or nursing facility and do not want CPR if your heart should stop, you should talk to your doctor about a DNR order. This order will prevent staff from performing CPR on you if your heart and breathing stop while you are a patient in a facility, but it will not remain active once you leave the hospital or nursing facility. If you wish to have a DNR in place once you are discharged, you must acquire a Michigan Do Not Resuscitate order. (Usually, people don't make this decision until they are ill or frail enough that it would not be a surprise if they were to die in the next 12 months.) It is important to know that a DNR does not mean that you will receive no treatment. You may receive aggressive comfort measures, or other appropriate treatments, when you have a DNR order, if that is your wish.

If you feel that this is the right choice for you because of your medical circumstances, speak to your physician about obtaining a Michigan Do Not Resuscitate order. Once you have this order, you will be given a paper and possibly a bracelet to wear that will instruct others to *not* perform CPR on you if your heart and breathing should stop. If your heart and breathing stop, and someone calls 911, emergency responders are obligated to treat you unless they see evidence of a Michigan DNR order.

Please speak with your physician regarding this important decision. Also, make sure that your loved ones understand this and do not call 911, but rather, help you have comfort measures in place if your condition should worsen. (It may be helpful for you to have hospice care in place if you are electing this option. You may also discuss these issues with an advance care planning facilitator or social worker in your local medical center or hospital, or by contacting a local hospice provider.)

Page 4 of your Designation of Patient Advocate Form gives instructions for your care. **When you complete your form, you will want to *cross out and initial* any instructions *you do not want***. Please ask to speak with a physician, nurse, social worker or advance care planning facilitator if you do not understand any of these instructions.

Important! Remember all of the things you have considered in the previous pages of this workbook when you decide what you might fill out in this section of your Designation of Patient Advocate Form. You may also add comments on page 8 of your Designation of Patient Advocate Form under the section entitled, "Things I Want My Patient Advocate to Know."

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, transfer of 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. Hire and discharge physicians, nurses, therapists, any other healthcare 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 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:

_____

_____

DRAFT WORKSHEET ONLY

This page (page 5) is one of the most important parts of your Designation of Patient Advocate Form, because it will be used to determine what types of life-sustaining treatment you may or may not want in certain situations. Please read through this section carefully in this workbook before selecting an option. If you do not understand these options, please speak with a physician, nurse, social worker or advance care planning facilitator before completing this section in your final Designation of Patient Advocate document.

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.

b. 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: _____

c. Additional Specific Instructions Regarding Care That I DO or I DO NOT Want:

_____

_____

_____

_____

DRAFT WORKSHEET ONLY

This portion of your Designation of Patient Advocate Form (**page 6**) can be difficult to understand. In this workbook, we have included comments after each section that will clarify what these options mean. Completing any or all portions of this page of the Designation of Patient Advocate Form is optional.

Optional Provisions

The following designation, authorizations, and waiver are optional. If you choose to affirm any of the options, please check the corresponding box and sign where indicated.

☐ Specific Instructions Regarding Organ and Tissue Donation: 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.

(Organ donation can be performed when specific conditions are met, including declaration of brain death and patient remaining on a ventilator. The donation process is usually completed within two days of determining that the individual is a viable donor.)

☐ I wish to designate a particular physician and/or mental health practitioner to examine me and make the determination as to my ability to participate in medical treatment decisions.

The individual I wish to designate is: _____

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

(You may identify a physician to determine your mental health status, and if that physician is available and willing, they would assess your need for treatment.)

☐ I authorize my Patient Advocate to consent to the forced administration of medication related to mental health treatment. I authorize my Patient Advocate to consent to inpatient hospitalization related to mental health treatment.

(Sometimes, mental health treatment is necessary to help a person stay safe and not be a danger to themselves or others. If this situation occurs, your advocate can require you to take prescribed medications or get prescribed mental health treatment until you are no longer a danger to yourself or others. If you do not have an advocate for mental health, you can sometimes be court-ordered to get treatment if you are a danger to yourself or others.)

☐ I waive my right to immediately revoke my Patient Advocate designation as to mental health treatment decisions. By waiving this right, I understand that any future attempt to revoke my Patient Advocate designation as to mental health treatment decisions will be delayed for 30 days.

(You always have the right to revoke your advocate. However, if you become a danger to yourself or others, and you sign here, your advocate may still make decisions regarding your mental health treatment for up to thirty days. This would be done so that you could receive uninterrupted treatment to make sure that you are no longer a danger to yourself or others.)

This document is to be treated as a Durable Power of Attorney for Healthcare 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.

DRAFT WORKSHEET ONLY

The exercise below is provided to help prepare you for the next portion of your Designation of Patient Advocate Form, found on **pages 7-8**, which states: "The following are my personal preferences that may or may not be appropriate, or possible, given the unknown circumstances I may face in the future. I ask that these preferences be considered and honored when possible, reasonable, and medically and financially appropriate. I authorize my Patient Advocate to make final decisions in these matters when dealing with future circumstances in which these preferences become relevant."

This section addresses various advance care planning topics, giving a variety of preferences for you to consider for each topic.

It is important to note that this section of your Designation of Patient Advocate Form discusses your preferences and wishes regarding future healthcare-related topics. This section is provided to help you communicate your values and wishes to your loved ones and those who will be making decisions regarding your future healthcare treatment. **This is not a legally-binding portion of your document.** It is meant to convey your preferences to your Patient Advocate in a number of potential situations. Your Patient Advocate will always consider, and in most cases adhere to, your preferences. But, future facts and circumstances may require alternative treatment decisions.

Please read and check any of the boxes by the statements that are *especially* important to you and cross off those that you do not agree with. **You may want to write some of these statements in the spaces provided on pages 7-8 of your form, or you may wish to write in statements of your own that best describe your preferences.** (If you are not familiar with some of the terms, please see the definitions provided in the glossary in the back of this workbook.)

Example:

Regarding Hospice:

☒ If I am diagnosed with a terminal condition, I wish to have hospice care when I am done attempting curative treatments. Please see that I have hospice early so I may appreciate the benefits provided by this service.

☐ ~~If I am diagnosed with a terminal condition, I do not want hospice care as I would like to seek curative treatment as long as possible.~~

Regarding Palliative Care (Symptom Management)

☐ Please see that I have palliative care if I have a chronic, progressive or terminal diagnosis.

☐ Please know that comfort is more important to me than having more time.

☐ Comfort is more important to me than being completely aware. If I am unable to speak for myself, please prioritize my comfort over awareness.

☐ I value alertness and being aware of my surroundings, actions and visitors more than I value freedom from pain or other symptoms. Please use this as a reference when determining treatment for my level of pain and other symptoms.

☐ I view suffering as a natural part of life and not necessarily a fate to be avoided, but rather a passage that must be endured. When I can no longer speak for myself, please see that I am reasonably comfortable, but not rendered unaware if possible.

DRAFT WORKSHEET ONLY

Regarding Long Term Care or Housing

- ☐ It is important to me to remain in my home if possible. I believe that I have adequately prepared for this and ask that this request be honored.
- ☐ Though it is important to me to remain in my home, I understand that my care may become burdensome and I would not want this. If in-home help is not an option, please select a living situation that respects my personal values.
- ☐ I trust my advocate to make the best decisions for me given the situation and level of care that I need.

Regarding Artificial Nutrition/Hydration or Tube Feeding

- ☐ I view pleasure from food as an essential part of life. If I cannot enjoy eating by mouth, please do not tube feed me. I view this as unnatural.
- ☐ I believe that if I am unable to take food by mouth, or if I have lost interest in eating, this is a natural process that should be respected. Please do not feed or hydrate me via tube or IV.
- ☐ I view freedom from hunger as a basic human right. If I cannot eat by mouth, please nourish me through tube feedings if possible.

Regarding Hospice:

- ☐ If I am diagnosed with a terminal condition, I wish to have hospice care when I am done attempting curative treatments. Please see that I have hospice early so I may appreciate the benefits provided by this service.
- ☐ If I am diagnosed with a terminal condition, I do not want hospice care as I would like to seek curative treatment as long as possible.

Regarding My Views on Life

- ☐ I view my life as sacred. Please do anything and everything you can to prolong it.
- ☐ I view my life as sacred and therefore believe in something after my life is over. Therefore, I do not want any interventions that needlessly prolong my existence here if I have a terminal or irreversible condition. Please view my natural death as a means to something better for me.
- ☐ I view my life as a temporary allowance. I do not perceive any reason to think that there is anything to stay here for or to move onto. Please allow me dignity in my final days by following my requests as much as possible.

DRAFT WORKSHEET ONLY

Regarding Special Preferences

- ☐ If possible, when appropriate, I would like to be outside, or at the very least, have windows open.
- ☐ Please keep me clean and dry if I have lost control of my bladder and/or bowels.
- ☐ Please keep my mouth moist if possible.
- ☐ Please surround me with my favorite belongings, music, etc.
- ☐ Please allow my pet(s) to be with me if possible.
- ☐ The people I would like with me, if possible, are: _____
  _____
- ☐ The people I do not want with me are: _____
  _____

Regarding Final Thoughts and Hopes

- ☐ I want my loved ones to know that I view my death as a transition to a much better place. I have peace.
- ☐ I ask forgiveness for anything I have done to hurt my loved ones and want them to know that I have forgiven them for any hurts they may have caused me.
- ☐ I wish to retain my autonomy in as many decisions as possible.
- ☐ I wish to have people with me as much as possible.
- ☐ I am uncomfortable with strangers and ask that strangers not be around me if possible.
- ☐ I consider myself a spiritual being and wish to have rites of my religion performed, including:
  _____
- ☐ I do not consider myself to be spiritual or religious and request that spiritual or religious activities not be performed around me.
- ☐ I value peace and quiet and ask that this be respected when possible.
- ☐ Please let me know that I am not alone, even if it appears that I cannot hear you.
- ☐ It is my sincere desire that my family can be united. Please use my passing as a means to have a new beginning and forgive whatever grievances you might have with one another or with me. It would give me great peace to know that my family remains united by love after I am gone.
- ☐ Please do not allow my passing to become a wound that won't heal or that changes you in a negative way. Grieve me as you need, but please, move forward. Know that I have accepted that we all must die. Please find your peace with this and know I want you to be happy.
- ☐ I ask that my loved ones and caregivers please excuse any new behaviors I may have that are not consistent with the person you have known me to be before I was sick, frail or elderly.

DRAFT WORKSHEET ONLY

(*Final Thoughts and Hopes* continues on next page)

Regarding Final Thoughts and Hopes (Continued)

☐ The things I want you to remember about me are: _____
_____
_____
_____
_____
_____
_____

☐ After I die, I would like my body to be cremated.

☐ After I die, I would like my body to be buried in (location) _____.

☐ I want my wishes regarding organ donation to be honored despite the desires, needs or opinions of those around me.

☐ After I die, I would like my body to be donated to _____.
(I have made the proper arrangements for this.)

☐ I have discussed my wishes regarding a funeral/memorial service with:
_____

Other Things I Want My Patient Advocate to Know

☐ I want you to know that I appreciate your willingness to honor these wishes whenever possible.

☐ Please know that these wishes are very important to me, even if you do not agree with them.

☐ Do not allow yourself to feel guilt for honoring these wishes, but instead, know that it meant the world to me that you were kind enough to honor me in the ways I requested.

☐ Please fill in any other requests or statements here:_____
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(Attach additional sheets of paper if necessary.)

DRAFT WORKSHEET ONLY

In this portion of your Designation of Patient Advocate Form, (page 9), you will sign your document. **You may complete the rest of your document alone, but it must be signed, after you have completed it, in the presence of two witnesses**. The rules for who can act as a witness are very strict. When you are ready to sign your document, make sure that your two witnesses meet the requirements listed below.

The individuals are:

- At least 18 years of age
- Of sound mind

The individuals are *not*:

- Your husband or wife, parent, child, grandchild, grandparent, brother or sister
- Your presumptive heir
- A known beneficiary of your will at the time of witnessing
- Your physician
- A person named as your Patient Advocate
- An employee of your life or health insurance provider
- An employee of a health facility that is treating you
- An employee of a home for the aged where you reside

Don't sign here unless you are in the presence of two witnesses who fulfill the requirements listed in this section!

Signature

Sign Name _____ Date _____

Name _____
type or print

Address _____

Witness Statement And Signatures

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, grandparent, 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. I am at least eighteen years old and of sound mind.

Sign Name: _____	Sign Name: _____
Print Name: _____	Print Name: _____
Address: _____	Address: _____
_____	_____
Date signed: _____	Date signed: _____

Remember: Your Designation of Patient Advocate Form will not be legally enforceable unless this page is completed as directed! All dates on this page must match.

DRAFT WORKSHEET ONLY

This portion of your Designation of Patient Advocate Form (pages 10-11) gives your Patient Advocate(s) information regarding their rights and responsibilities. If they agree to act as your Patient Advocate, they will sign on the next page. **Your Patient Advocate's signature does not need to be witnessed, but the signature must be on the document before they can speak on your behalf in a crisis or healthcare emergency**. Because of this, make sure that your Patient Advocate(s) sign this form right away. By doing this, you can avoid delays in the hospital or physician receiving guidance for your healthcare choices during a future crisis.

Patient Advocate Designation Acceptance

I, _____, accept the designation of Patient Advocate for _____, and I agree to perform the duties given to me as Patient Advocate, subject to the terms, conditions and restrictions specified below.

(a) **Effective**. This designation will not become effective unless the patient is unable to participate in medical or mental health treatment decisions.

(b) **Limitations**. I will not exercise powers concerning the patient's medical or mental health treatment that the patient, if able to participate in the decision, could not have exercised on patient's own behalf.

(c) **Pregnancy**. I will not make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant if it would result in the patient's death.

(d) **Withholding of Treatment**. I will not make a decision to withhold or withdraw treatment that would allow the patient to die unless the patient has clearly expressed that I am authorized to make such a decision, and that he or she understands such a decision could cause his or her death.

(e) **Compensation**. I will not receive compensation for the performance of my responsibilities, but I may be reimbursed for expenses.

(f) **Fiduciary Standards**. I will act consistent with the patient's best interests. The desires of the patient expressed while able to participate in treatment decisions are presumed to be in the patient's best interests.

(g) **Revocation of Designation**. The patient may waive his or her right to revoke the designation immediately, at any time, by expressing his or her intent to revoke (except as provided under paragraph h below).

(h) **Waiver**. The patient may waive the right to immediately revoke the designation as to mental health treatment. If the patient waives this right, any attempt by the patient to revoke his or her designation as to mental health will not be effective until a period of 30 days has passed.

(i) **Revocation of Acceptance**. I may revoke this acceptance at any time by expressing my intent to revoke.

(j) **Patient Rights**. A patient admitted to a health facility has the rights listed in Section 333.20201 of the Michigan Compiled Laws, as amended.

(k) **Anatomical Gifts**. My authority to make a donation of bodily organs may be exercised after the patient's death.

Continued on next page.

DRAFT WORKSHEET ONLY

This is the continuation of the Patient Advocate Designation Acceptance portion of your document. You must have your Patient Advocate(s) sign below in order for them to be able to act as your Patient Advocate.

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

Print name: _____ _____
Patient Advocate's Signature

Successor Patient Advocate

Print name: _____ _____
Successor Patient Advocate's Signature

Successor Patient Advocate

Print name: _____ _____
Successor Patient Advocate's Signature

Your Patient Advocate's signature does not need to be witnessed, but the signature must be on the document before they can speak on your behalf in a crisis or healthcare emergency. Because of this, it is important to have your advocate(s) sign it right away.

DRAFT WORKSHEET ONLY

Document Tracking: This portion, found on page 11, is to help you keep track of who has been given copies of your document in the event that you need to update your current copy.

Keep the signed original with your personal papers at home. **Please give a copy to your Patient Advocate(s), your physician, and the hospital where you are likely to receive treatment.** If you decide to update this document, please be sure to revoke all copies that you have distributed. You may do this by writing "revoked" across the document, or by disposing of the document. Once you have revoked a version of this document and created a new one, make sure that all parties who need a copy are given copies of your revised document. (Complete the following so that it will be easy to track your documents should you ever revise or replace your current document.) **The Designation of Patient Advocate Form must be copied in it's entirety, even if sections are left blank.**

I have given copies of my Designation of Patient Advocate Form to the following:

_____ _____

_____ _____

_____ _____

_____ _____

Starting YOUR Conversation

Having conversations about the important topics in this workbook will be very helpful as you prepare to complete your Designation of Patient Advocate Form. These conversations will also help your loved ones know, in advance, what kinds of healthcare you would want in different situations. Below are a few of the main topics you will want to discuss with your family, friends and Patient Advocate(s):

- CPR
- Artificial Nutrition/Hydration
- Other Life-Sustaining Treatments
- Mental Health (including advanced dementia)
- Organ and Tissue Donation
- Pain Management and Comfort
- Hospitalization
- Living Arrangements

Starting a conversation about illness, injury or end-of-life matters can be uncomfortable, or even frightening for some. Having prepared conversation starters can help. The following types of phrases may help you begin your conversation with your loved ones:

"I was thinking about when grandpa died and how helpful hospice was. I really want to be sure that people know what I want when my time comes…"

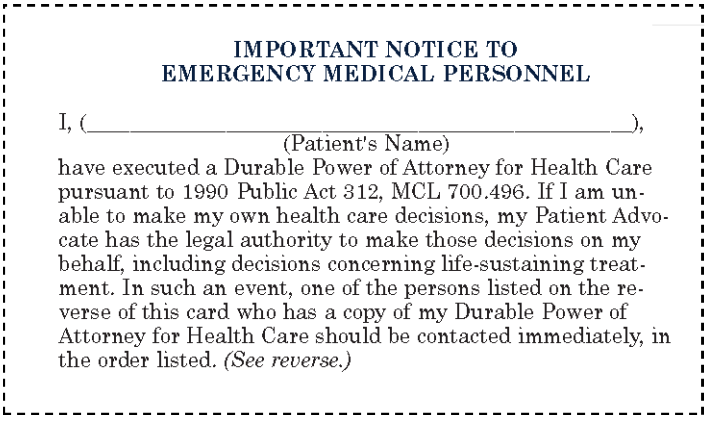
"I was thinking about how grandmother died and I really don't want to die like that…"

"I saw a movie about a woman who was diagnosed with a terminal illness and I started thinking about what I would want to do if I received a terminal diagnosis…"

"My life has been so good; I've had great health and a wonderful family. I was thinking about how important it is to make sure that the end of my life goes well, too…"

"I recently saw the doctor, and even though I'm in great shape now, I think it is time to start thinking about my future health and what I might want to do if I ever have a serious illness or injury…"

Your Designation of Patient Advocate Form contains a cut-out **Durable Power of Attorney for Healthcare Wallet Card** on page 11. Please follow the instructions and keep this wallet card with you at all times. In the event of an accident in which you cannot speak for yourself, emergency responders will know to look in your wallet to identify you and determine how to contact your Patient Advocate should they need to speak with them.



IMPORTANT NOTICE TO
EMERGENCY MEDICAL PERSONNEL

I, (_____),
(Patient's Name)
have executed a Durable Power of Attorney for Health Care pursuant to 1990 Public Act 312, MCL 700.496. If I am unable to make my own health care decisions, my Patient Advocate has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatment. In such an event, one of the persons listed on the reverse of this card who has a copy of my Durable Power of Attorney for Health Care should be contacted immediately, in the order listed. *(See reverse.)*

Glossary

Allow Natural Death (AND):
Allow Natural Death, or AND, is a treatment choice regarding how an individual would like to spend their final months, days and hours. When choosing AND, a patient has determined to forego aggressive or invasive measures that do not provide comfort and instead focus on quality of life for the time that remains before their death. In this treatment choice, physicians and healthcare providers will attend to spiritual, social and physical needs by providing quality comfort care and by encouraging the presence of family, friends and loved ones.

Advance Care Planning:
Advance Care Planning is an organized process of communication to help individuals understand, reflect upon and discuss goals for future healthcare decisions in the context of their values and beliefs.

Artificial Nutrition/Hydration – Tube Feeding:
Tube feeding provides artificial nutrition to those who can't eat enough calories by mouth or are unable to eat. A feeding tube for short-term use can be run through the nose and into the stomach. A feeding tube for long-term use may be inserted through a small hole surgically cut in the stomach.

Brain Death:
Brain death is the complete and irreversible loss of brain function (including involuntary activity necessary to sustain life). A patient may be pronounced brain dead even if their heart continues to beat.

Cardiopulmonary Resuscitation (CPR):
CPR is used to try to restart the heart and breathing after both of these have stopped. CPR includes both: 1) pushing on the chest to try to restart the heart and 2) giving air by the mouth or a tube down the airway to the lungs. Shocking the heart with electricity or giving medicine into the bloodstream may also be needed. This type of medical care requires follow up in the hospital emergency department and likely an intensive care unit (ICU) so that a ventilator (breathing machine) and a heart monitor can be used. While this is important in an emergency, there are some situations that could make it ineffective or even undesirable. It is important that you discuss this with your doctor.

Comfort Measures Only:
Comfort Measures Only is a treatment choice that prioritizes comfort over trying to acquire more time when death is likely to happen soon.

Extraordinary Measures (Disproportionate):
Extraordinary measures refers to treatment options that are accompanied by excessive cost, pain, or other inconvenience, or which would not offer a reasonable hope of benefit.

Hospice:
Hospice is a service or type of care that is designed specifically for those who have a terminal illness that will limit an individual's life expectancy to six months or fewer. Hospice is provided only after curative treatment is discontinued. Hospice is a multi-disciplinary approach, meeting the physical, spiritual and emotional needs of the individual, while also addressing the spiritual and emotional needs of those in the unit of care (loved ones/family).

Mechanical Ventilation/Breathing:
Mechanical ventilation is the use of a machine to support breathing. Its purpose is to: 1) assist a person having difficulty breathing, or 2) try to restore breathing because a person has stopped breathing or lost the ability to breathe on his/her own. Mechanical ventilation is done by placing a tube in the airway, through the nose or mouth and into the lungs. The tube is then connected to a machine called a ventilator, respirator, or a breathing machine. Mechanical ventilation can make it impossible to speak and can cause anxiety for some, requiring restraints to prevent injury from self-removal of the breathing tube.

Non-Beneficial Treatment (Futility):
Non-beneficial treatment options include treatments that may have some positive results, but ultimately will not make a difference in the outcome. They may even prolong life, but they will never cure or correct the current condition.

Ordinary Measures (Proportionate):
Ordinary measures refers to treatment options that offer reasonable hope of benefit and do not cause excessive expense, pain, or other inconvenience.

Organ Donation:
Organ donation refers to the removal of organs for the purposes of assisting another. This can be done only under specific conditions, including declaration of brain death and continuation of ventilation. Organ donation involves the recovery of lungs, kidneys, heart, liver, pancreas and sometimes intestines. The process is usually completed within two days of declaration of brain death.

Palliative Care:
Palliative Care is a specialized treatment option for individuals with a serious illness, providing a multi-disciplinary approach that focuses on symptom management, regardless of whether or not curative treatment is sought. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a specially-trained team of doctors, nurses and other specialists (social work, clergy, etc.) who work together with a patient's physician/provider to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness.

Patient Advocate:
This is the person you trust and select to speak on your behalf regarding medical decisions if you are ever unable to speak for yourself.

Refusal of Life-Sustaining Interventions:
Refusal of life-sustaining interventions refers to the decision to avoid, or *not* allow the introduction of life-sustaining interventions in a medical crisis.

Withdrawal of Life-Sustaining Interventions:
The withdrawal of life-sustaining interventions refers to the decision to remove or stop life-sustaining interventions after they have been started. It is important to note that the American Medical Association and Michigan Penal Code do not differentiate between the refusal and withdrawal of life-sustaining treatments in ethical, moral or legal terms.

As you reflect on the content and exercises in this workbook, please use the spaces below to record any questions you feel you must have answered before completing your document. *Also, list who could help you with these questions.* You may need to speak with your physician, attorney, spiritual advisor, an advance care planning facilitator, your Patient Advocate or loved ones in order to be entirely ready to complete you Designation of Patent Advocate Form. Please bring this workbook with you if you arrange to speak with any of these individuals when seeking answers to your questions below:

1) _____
_____

2) _____
_____

3) _____
_____

4) _____
_____

5) _____
_____

This completes your workbook information and exercise materials to help you prepare for completing your Designation of Patient Advocate Form!

HONORING
Healthcare Choices

If you would like assistance completing this workbook, or would like to schedule an advance care planning consultation to complete your Designation of Patient Advocate Form, please contact MidMichigan Health's Advance Care Planning Department at (989) 839-3167.