Advance Directive
For Health Care

Your patient advocate is the person you choose to make decisions about your health care if you become unable to make those decisions yourself. Your patient advocate may be a family member or a close friend whom you trust to make serious decisions. The person you name as your patient advocate should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

I, _____, am of sound mind, and I voluntarily make this designation.
(Print or type your full name)

I designate _____, my _____,
(insert name of patient advocate) (Spouse, child, friend, etc.)

living at _____,
(Address of patient advocate)

who can be reached at _____,
(Contact numbers for patient advocate)

as my patient advocate. This person has been chosen to make care, custody and medical treatment decisions for me if I become unable to participate in medical decisions.

You can choose a second person as your alternate patient advocate. This successor will step in if the first person you name as an advocate is unable, unwilling, or unavailable to act for you.

If my first choice cannot serve, I designate _____,
(Name of successor patient advocate)

living at _____, who can be reached at
(Address of successor patient advocate)

_____, to serve as patient advocate.
(Contact numbers for successor patient advocate)

The decision that I am unable to take part in medical decisions shall be made by two physicians or a physician and a licensed psychologist.

In making decisions for me, my patient advocate shall follow my wishes that I have communicated verbally, or in a living will, or in this document.

My patient advocate has the right to consent to, or refuse treatment on my behalf, or to arrange medical services for me. This may include admission to a hospital or a nursing care facility. It may include paying for such services with my funds. My patient advocate shall have full access to any of my medical records.

This Advance Directive for Health Care is provided as a service of:

Lakeland HealthCare
Medical Excellence. Compassionate Care.

Optional

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and acknowledge such decisions could or would allow my death.

_____

(Sign your name here if you wish to give your patient advocate this authority)

Optional

I expressly authorize my patient advocate to request information about hospice and palliative care services upon my physician's recommendation, or at any time when my patient advocate believes that I could benefit from hospice and palliative care services.

_____

(Sign your name here if you wish to give your patient advocate this authority)

Optional

Michigan law permits a person to authorize organ and tissue donation, along with whole body donation, while they are alive. This authorization, known as first person consent, cannot be revoked or amended by any person, including a patient advocate. All gifts listed are effective upon my death.

My patient advocate should be aware that (*check any that reflects your wishes*):

☐ I am aware that organ and tissue donation may require mechanical support in order to maintain viability of the organs for transplant. The need to maintain organs for life-saving transplants does not in any way conflict with any other end-of-life measures outlined in this document. My wish is that lives are saved through donation prior to withdrawal of any mechanical support at the time of my death.

☐ I authorize donation of any needed organs or body parts for the purposes of transplantation, therapy, research and education. (Note: For appropriate notification at the time of death, this should be accompanied by joining the Michigan Donor Registry at www.giftoflifemichigan.org/become_a_donor)

☐ I authorize donation of all EXCEPT the listed organs or body parts for the purposes of transplantation, therapy, research and education.
All organs and body parts EXCEPT _____

☐ I have made prior arrangements to donate my entire body for anatomical study with the following program: _____

_____

(Sign your name here if you wish to give your patient advocate this authority)

My specific wishes concerning health care are the following: (if none, write "none") *Attach another page if necessary*

_____

_____

_____

_____

I may change my mind at any time, and communicate in any manner, that this document does not reflect my wishes.

It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability when my wishes are honored as written here, or when the decisions of my patient advocate are carried out.

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

I sign this document after careful consideration. I understand its meaning. I accept its consequences.

Signed: _____ Date: _____

Address: _____ Birthdate: _____

Notice Regarding Witnesses

The law requires that you sign your designation in the presence of two witnesses.
These witnesses **cannot** be:

- Your spouse, parent, child, grandchild, sibling, physician or your patient advocate.
- A person who stands to inherit from your estate.
- An employee of your life or health insurance carrier.
- An employee of a health care or mental health care facility where you are being treated.
- An employee of a home for the aged, if you are a patient in that facility.

Statement of Witnesses

We sign below as witnesses. This form was signed or acknowledged in our presence. The person who signed appears to be of sound mind and appears to be making this decision voluntarily, without duress, fraud or undue influence.

Signed by witness: _____ Date: _____

Print or type name: _____

Address: _____

Signed by witness: _____ Date: _____

Print or type name: _____

Address: _____

Acceptance by Patient Advocate

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

(B) A patient advocate shall not exercise powers which concern the patient's care, custody and medical treatment that the patient, if they were able to participate in the decision, could not have made on his or her own behalf.

(C) If the patient is pregnant, this designation cannot be used to make a medical treatment decision to withhold or withdraw treatment 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, but only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision. The patient must acknowledge that such a decision could or would allow a patient's death.

(E) A patient advocate shall not be paid compensation for the performance of his or her authority, rights, and responsibilities. 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 good faith when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or shown 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 change his or her designation at any time and in any manner.

(H) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner.

(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.

I understand the above conditions and I accept the designation as **patient advocate** for:

_____

Signed: _____ Dated: _____

I understand the above conditions and I accept the designation as **successor patient advocate** for:

_____

Signed: _____ Dated: _____