Advance Care Plan/Power of Attorney for Healthcare

Print Patient Name: _____ Date: _____

Date of Birth: _____

Emergency Contact *(this does not have to be your Patient Advocate):*

Name: _____ Phone: _____

Only complete this box if someone other than the patient is completing this form:

*Person completing form:*_____ *Date:* _____

Relationship: _____

Why patient can't complete (Unable to write due to eyesight, shaking hands, etc.):

Appoint a Patient Advocate

Your Patient Advocate is the person who can make medical decisions for you (such as care, custody, medical, or mental health treatment decisions) if you are too sick or unable to make them yourself. If you are very sick and *two doctors decide* that you cannot make your own medical decisions, they will ask that your Patient Advocate make them for you. Select someone you trust to make the decisions you would want. You may also name one or more persons to make the decisions if your first choice cannot. These additional persons would be your First and Second Alternate Patient Advocates. By Michigan law, only one person may speak for you at a time, in the order that you named them.

I want this person to be my Patient Advocate if I can no longer make medical decisions for myself.

1. Primary Advocate: _____

If the first person cannot do it, then I want this person to make my medical decisions when I cannot and be my successor Patient Advocate.

2. First Alternate Advocate:_____

If the first person cannot do it, then I want this person to make my medical decisions when I cannot and be my successor Patient Advocate.

3. Second Alternate Advocate: _____

Accepting the Role of Patient Advocate

As the Patient Advocate:

- You should always act with the patient's best interests and not your own interests.
- You will only start making decisions for the patient after *2 doctors agree* that the patient is too sick to make his or her own decisions.
- You will not be able to make decisions that the patient would not usually be able to make.
- You don't have the power to stop a pregnant patient's treatment if it would cause her to die.
- You can make a decision to stop or not start treatments and allow the patient to die naturally.
- You cannot be paid for your role as a Patient Advocate, but you can get paid back for the money you spend on the patient's medical expenses.
- You should help to protect the patient's rights as defined by law.
- You cannot make decisions that go against the patient's wishes regarding organ donation.
- The patient can remove you as Patient Advocate whenever they want.
- You can remove yourself as Patient Advocate whenever you want.

Three Most Important Qualities of a Patient Advocate		
Be open to talking with the person as their health and life changes. Does the new situation change their wishes? You will need to know.	Do your best to honor their wishes, even if you don't agree with them. Your job is to be their voice, even if it's hard.	Be willing to advocate for them, even if it's uncomfortable. If you are asked to consider treatments or plans that you know don't fit with their wishes, you **must** speak up.

Signatures: Accepting the Role of Patient Advocate

Patient Name:_____ Date of Birth:_____

Primary Patient Advocate: **Name (print): _____**

Relationship: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

Address: _____

City/State/Zip: _____

Advocate Signature: _____ (Date): _____

First Alternate Patient Advocate: **Name (print): _____**

Relationship: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

Address: _____

City/State/Zip: _____

Advocate Signature: _____ (Date): _____

Second Alternate Patient Advocate: **Name (print): _____**

Relationship: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

Address: _____

City/State/Zip: _____

Advocate Signature: _____ (Date): _____

Signatures: Document Owner and Witnesses

Before this Advance Directive can be used, you must:

- Sign this form on Part B, Page 5, **while your witnesses are watching you.**
- Have 2 witnesses sign that same page **on the same day**.

Your witnesses **must**:

- Be at least 18 years of age.
- See you sign this form and sign it **on the same day**.

Your witnesses **cannot:**

- Be your Patient Advocate
- Be your health care provider
- Work for your health care provider.
- Work at the place where you live (if you live in a nursing home or group home.)
- Be your spouse, your parent, your child or grandchild, or your brother or sister.
- Benefit financially (get any money or property) after you die.
- Work for your insurance company.

Your 2 witnesses **do not** need to read this Advance Directive.

They **do need** to watch you sign the form and sign it themselves **on the same day**.

They sign to promise that while you signed the form, you appeared to be thinking clearly and were not forced to sign it. Some examples of whom your witnesses could be include neighbors, members of church, or friends.

You **do not** need a notary or a lawyer to complete this form.

Advance Directive Signature Page

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: ventilator (breathing machine) and cardiopulmonary resuscitation (CPR),– 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.***

1. Your Signature

Sign your name Date

Print Your First Name Print your Last Name

Street Address City State Zip

Date of Birth (Month/Day/Year)

2. Witnesses' Signatures

By signing, I promise that I watched the owner of this form sign it. They appeared to be thinking clearly and were not forced to sign it.

Witness #1

Sign your name Date

Print Your First Name Print your Last Name

Street Address City State Zip

Witness #2

Sign your name Date

Print Your First Name Print your Last Name

Street Address City State Zip

Make Your Health Care Wishes Known

The following are my thoughts concerning my health:

Today, in my current health

Put an X along this line to show how you feel today, in your current health.

My main goal is to live as long as possible, no matter what.

Equally Important

My main focus is on quality of life and being comfortable.

At the end of life

Put an X along this line to show how you would feel if you were so sick you might die soon.

My main goal is to live as long as possible, no matter what.

Equally Important

My main focus is on quality of life and being comfortable.

Your Thoughts on Life

Unacceptable outcomes (check all that apply)	**Things that are important to me:** (check all that apply)
☐ Not able to wake up or talk to my family and friends ☐ Not being able to live without being hooked up to machines ☐ Not being able to think for myself ☐ Not being able to feed, bathe, or care for myself ☐ Having my loved ones do my bathing and personal care ☐ Having non-family do my bathing and personal care ☐ Not being able to live on my own ☐ Being bedbound ☐ Having constant, severe pain or discomfort ☐ Something else:	☐ Communicating with my family and friends ☐ Activities with my family and friends ☐ Being as independent as possible ☐ Being able to feed myself ☐ Being able to bathe myself ☐ Being free from pain ☐ Being alert, even if that means I might have some pain ☐ Live without being hooked up to machines ☐ Live at home (as opposed to a nursing home) ☐ Something else:

Making Your Wishes About Life Support Known

If you cannot speak for yourself, your Patient Advocate will make decisions about life support for you. Life support treatments are medical care to try and help you live longer.

Talk with your health care provider, your family members, and Patient Advocate about the kind of treatment you do and do not want.

If I reach a point that doctors think there's very little chance I will recover my ability to know who I am, where I am, and who's around me:

- ○ I want to try everything that might help me live longer, even if it means I may be on life support equipment, such as a breathing machine or kidney dialysis, for the rest of my life.

- ○ I want my health care providers to try treatments for a period of time. However, I want to stop these treatments if they do not help, or if they cause me pain and suffering.

    - ☐ I know my Patient Advocate will be making this decision based on what's happening, but the amount of time I am comfortable being on life support is roughly:

      _____

      _____

    - ☐ Please postpone taking me off life support until (family arrives, second opinion, anything else that is important to you):

      _____

      _____

- ○ I want to die a natural death. I want no life support treatments.

Treatment Preferences (Goals of Care)

Cardiopulmonary Resuscitation (CPR) *(Please see page 6 in your booklet for important facts to help you decide what's right for you.)*

If my heart or breathing stops:

- ○ **I want** CPR in all cases.
- ○ **I want** CPR unless my health care providers determine that I have any of the following:
  - An injury or illness that cannot be cured and I am dying.
  - No reasonable chance of surviving if my heart or breathing stops.
  - Little chance of surviving long term if my heart or breathing stops and it would be hard and painful for me to recover from CPR
- ○ **I do not want** CPR but instead want to allow natural death. *Note: If you choose this option, you will need to complete an additional form called a "Do Not Resuscitate" (DNR) form. First responders must be provided either a copy of this form or a medical bracelet meeting state requirements in order to withhold CPR. This form must be signed by your physician and can be obtained at your doctor's office, through an Advance Care Planning Facilitator, or by calling (269) 983-8166.*

NOTE: If either of the first two options are initialed (CPR will be attempted), "Advanced Interventions" must also be checked below. Life support is often necessary after receiving CPR.

Medical Interventions (Help with Breathing) *(Please see page 7 in your booklet for important facts to help you decide which option is right for you.)*

If my heart or breathing have not stopped, but I am struggling to breathe:

- ○ **I want advanced interventions:** I would like to try any aggressive care options that my doctor recommends, including a ventilator. I understand that this means I will need to be in the hospital, in intensive care, and that there is a chance I may need long-term ventilator care.
- ○ **I want limited interventions:** DO NOT intubate me or put me on a ventilator. I am willing to try a tight-fitting mask or other non-invasive measures that my doctor recommends, such as IV fluids or a heart monitor. I understand that I will need to be in the hospital, but I would like to avoid intensive care.
- ○ **I want comfort measures only:** I want to receive treatment and care to keep me comfortable, like oxygen and medication to decrease anxiety. I would like to stay at home if possible. I understand that this would not prolong my life.

What's Meaningful to Me:

Is religion or spirituality important to you? ◯ No ◯ Yes

I belong to this faith/faith community: _____

I would like someone called for spiritual support if I am nearing the end of my life ◯ No ◯ Yes

If yes, please call: _____

What are some other things that bring you comfort? *(Examples might be music, pets, having family and friends nearby, favorite movies/shows, fresh air, warm blankets, etc.)*

_____

_____

_____

_____

_____

_____

If I am dying, I would prefer to be: ◯ At home ◯ In a hospital ◯ Not sure

I want my health care team to know this about my religion or spirituality:

_____

If I'm nearing my death, I'd like the room to be like this *(people, pets, quiet, loud, happy, calm, etc.)*

_____

_____

_____

_____

_____

_____

Preferences for Organ/Tissue Donation

Your doctors may ask about organ donations after you die. If your Patient Advocate is not next-of-kin and you would like your Patient Advocate to make choices on your behalf after you have died, please complete a Funeral Representative Designation Form *(call (269) 983-8166 or email SHLACP@spectrumhealth.org if you need one of these forms.)*

My wishes about organ donation *(check the one you're most comfortable with. Your Patient Advocate must follow your wishes regarding organ donation according to Michigan law):*

- ○ I want to donate any parts of my body that may be helpful to others.
- ○ I want to donate only these organs: _____

  _____
- ○ I do not want to donate my organs.
- ○ I want to donate my body to an institution for research or training purposes. *(This must be set up with that organization ahead of time.)*
  - ☐ I have arranged to donate my body to the following institution:

    _____

    _____

Preferences for Burial/Cremation and Funeral

If your Patient Advocate is not next-of-kin and you would like your Patient Advocate to make choices on your behalf after you have died, please complete a Funeral Representative Designation Form.

When I die, I would like to be ◯ Buried ◯ Cremated ◯ My next-of-kin can decide

If you would like someone other than your closest relative to make decisions about your funeral, you must complete a Funeral Representative Designation Form to give them that right, otherwise it goes to family. You can get one of these forms from the funeral home you plan to use, or by calling (269) 983-8166.

The funeral home I'd like to use is:

_____

I have pre-planned my funeral with the above funeral home ◯ No ◯ Yes

Advance Directives
Final Checklist

Use this checklist to make sure you have everything in place.

- ☐ Chosen a trusted person to be your Patient Advocate
- ☐ Identified two people who are not your Patient Advocate, your family members, or part of your health care team to be your witnesses.
- ☐ Signed the form in front of the witnesses.
- ☐ Had your witnesses sign the form.
- ☐ Had your Patient Advocate sign the form.
- ☐ If you would like, complete the card at right and keep it in your wallet.

_____

Print your name Signature Date

I have a Durable Power of Attorney for Health Care

I have discussed my care with my patient advocate, family, and doctor. If I am unable to speak for myself, please contact:

_____

Advocate Name Phone #

What do I do next?

- ☐ Make copies of your form
- ☐ Give a copy to your health care provider and ask them to add it to your medical record. If you go outside Spectrum Health for care, (for example to a nursing home or other health system,) give them a copy and ask them to add it to your medical record.
- ☐ Give a copy to each of your Patient Advocates
- ☐ Give copies to your family and friends, and anyone else who would be involved if you were nearing the end of your life (pastors, etc.)
- ☐ Keep a copy on your refrigerator in the bright pink EMS folder, or use the removeable sticker to write down where you keep the pink folder (make it easy so first responders can access it easily.) To get a pink folder and sticker, call (269) 983-8166.
- ☐ IF you have decided not to receive Cardiopulmonary Resuscitation (CPR) on Part C, page 3, complete a Do Not Resuscitate Order and keep copies with your Advance Directive. It's a good idea to keep extra copies of that form in convenient places, like your bag or the glove compartment. Make sure your Patient Advocates have a copy of it as well.

Review Your Plan

Review your Advance Directive annually, or whenever one of the "Five D's" occurs:

1. **Decade** – when you start each new decade of your life
2. **Divorce** – if you (or your Patient Advocate) experience a divorce or other major family change.
3. **Death** – When you experience the death of a loved one (did that experience change anything about your own wishes?)
4. **Diagnosis** – if you are diagnosed with a serious health condition.
5. **Decline** – If you experience a significant decline or deterioration of an existing heath condition.

Learn More About Advance Care Planning

"I already have a Power of Attorney."

Please take these important steps:

1. ***Review it.*** Does it clearly give permission for that person to make medical decisions for you? There is a difference between a Financial and Healthcare Power of Attorney. *Financial Power of Attorney documents do not give your chosen advocates the rights they need to make medical decisions for you if you can't speak for yourself.*

2. ***Update it and make sure your loved ones are aware.*** Does your document still match your wishes? Do the people who are speaking for you know what's in it? Make sure to tell anyone close to you what your wishes are – it will make things much easier on your advocate.

3. ***Make sure it's easy to find.*** Give copies to your advocates, your doctor (ask them to add it to your record,) and anyone close to you. When everyone's on the same page, it saves conflict and stress for all. Keep a copy on your refrigerator, especially if you have chosen not to receive CPR (*First Responders will need to see your Do Not Resuscitate Order or bracelet* in order to not give you CPR.) If you would like one of our bright pink EMS folders to keep it in, call or email us with your request, name and address.

What is a certified advance care planning facilitator?

A facilitator is someone who can help guide you through advance care planning conversations. You and others you choose can discuss your life experiences, what matters to you most, and how to make sure your healthcare matches who you are as a person. Email us at **SHLACP@spectrumhealth.org** for a no-cost appointment, or call **(269) 983-8166.**

Advance Care Planning in your circles.

Speakers are available to talk to any size group on advance care planning at no charge throughout southwest Michigan. This topic is useful for many groups, since everyone over 18 should have a decisionmaker named in case of emergency. Group facilitations are also available. To request a speaker, please contact us at **SHLACP@spectrumhealth.org**

Any questions? Contact us.

Contact us at **SHLACP@spectrumhealth.org**, or **(269) 983-8166.**