Advance Care Plan

For questions or assistance with completing this document, call **(269) 983-8166**

Document and Overview of Process

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 sudden illness), someone else will have to make those decisions for you. You can choose the person you want to make decisions – 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 would want.

You should thoughtfully identify your personal values, beliefs, wishes and treatment goals regarding end of life care. With those values and beliefs in mind, you should then choose your Patient Advocate. Your Patient Advocate needs to learn your treatment goals and values, and be willing to act on your behalf, if and when necessary.

In Michigan, two physicians – or your attending physician and a licensed 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 "Accepting the Role of the Patient Advocate" (or a similar form) before acting on your behalf.
- Your Patient Advocate may decide to refuse or stop life-sustaining that would not help you achieve your goals of care. Such decisions could or would allow your death.

NOTE: This Advance Directive will replace any Advance Directive you have completed in the past. You may change your mind about your Patient Advocate designation at any time by communicating in any manner that this designation does not reflect your wishes. A written, signed document is recommended, but not required.

PLEASE NOTE:

Your Patient Advocate may be a spouse or relative, but it is not required. 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 for future medical decision-making.

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.

In summary, a good Patient Advocate must be able to serve as your voice and honor your wishes.

Instructing Your Patient Advocate

It is important for you to educate and 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 also important for your Patient Advocate to know any particular concerns you have about medical treatment, especially any treatment you would refuse or want stopped. It is important to understand that under Michigan law *your Patient Advocate may decide to refuse or stop life-sustaining that would not help you achieve your goals of care. Such decisions could or would allow your death.*

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.

Your Patient Advocate will have your permission to:

- Make choices for you about your 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.

- Interpret any instructions you have given in this form (or in other discussions) according to his or her understanding of your wishes and values;

- Review and release your medical records, mental health records, and personal files as needed for your medical care;
- Arrange for your 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 you have given for your care.

Advance Care Plan/Power of Attorney for Healthcare

Print Patient Name: _____ Date: _____

Where I would like to receive hospital care (whenever possible): _____

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

Name: _____ Phone: _____

Designation of Patient Advocate

(Print name of advocates – ***patient must write advocate's name***. *If writing is not possible, patient can make as much of a mark as possible, and facilitator or witness must indicate why writing is not possible and initial. Patient may also request that advocate print name, with facilitator or witness giving indication why writing is not possible and initialing.)*

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

*Person completing form:*_____

Relationship: _____

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

_____

Person completing form initial: _____ *Date:* _____

1. Primary Advocate:

I designate: _____
as my patient advocate to make care, custody, medical, or mental health treatment decisions for me in the event that I become unable to participate in medical treatment decisions. The determination of when I am unable to participate in medical and/or mental health treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

2. First Alternate Advocate: If my first choice is unable, unwilling, or not reasonably available to serve as my patient advocate,

I designate: _____
(Print name of alternate patient advocate ***patient must write advocate's name, or use modification above.***)
to serve as my patient advocate.

3. Second Alternate Advocate: If my second choice is unable, unwilling, or not reasonably available to serve as my patient advocate,

I designate: _____
(Print name of alternate patient advocate ***patient must write advocate's name, or use modification above.***)
to serve as my patient advocate.

Accepting the Role of Patient Advocate

The person executing this advance directive has asked you to serve as his or her Patient Advocate (or as an alternate Patient Advocate). Before agreeing to accept the Patient Advocate responsibility and signing this form, please:

1. *Read the **Introduction and Overview**, which provide important information and instructions.*
2. *Carefully read this completed form and;*
3. *Discuss, in detail, the person'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 make, if able.*
4. *If you are willing to accept the role of Patient Advocate, read, sign and date the following statement.*

I accept the person's selection of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the person as indicated within this "Advance Directive: My Patient Advocate" document or in other written or spoken instructions from the person. 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 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.

e) 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.

f) 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.

g) 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.

h) I may revoke my acceptance of my role as Patient Advocate 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 Michigan Public Health Code, (Exercise of Rights by Patient's Representative 1978 PA 368, MCL 333.20201).

Accepting the Role of Patient Advocate

Signature and Contact Information

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):** _____

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), cardiopulmonary resuscitation (CPR), 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.***

Signature of the Individual 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.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Address: _____

City/State/Zip Code: _____

Signatures of Witnesses: I know this person to be the individual identified as the "individual" signing this form. (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 believe him or her to be of sound mind and at least (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: _____

City/State/Zip Code: _____

Witness Number 2: Signature: _____ Date: _____

Print Name: _____

Address: _____

City/State/Zip Code: _____

Treatment Preferences (Goals of Care)

(this section is optional, but recommended)

Specific Instructions to my Patient Advocate

When I am not able to decide or speak for myself, the following are my specific preferences and values concerning my health care:

Instructions throughout this document:

- Put your initials next to the choice you prefer for each situation
- Cross out the choices you do not want, ~~like this.~~

Treatments to Prolong My Life

If I reach a point where there is a reasonable medical certainty that I will not recover my ability to know who I am, where I am, and I am unable to meaningfully interact with others:

_____ I want all possible efforts to prolong life made on my behalf, even if it means I may remain on life-sustaining equipment, such as a breathing machine or kidney dialysis, for the rest of my life.

-OR-

_____ I want my health care providers to try treatments to prolong my life 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.

<u>Note</u>: If you choose this option, it's important to talk with your advocates about what "a period of time" means to you, as this is different for everyone. They will be getting updated information from medical staff, but it will provide them peace of mind to know your thoughts. For example, "I'd like to try it, but don't want to be on life support for longer than (24 hours; a week; a month…) if I'm not getting better."

-OR-

_____ I want to stop or withhold all treatments to prolong my life.

In all situations, I want to receive treatment and care to keep me comfortable.

In all situations, I want to receive treatment and care to keep me comfortable.

_____***I choose not to complete this section***

Treatment Preferences (Goals of Care)

(this section is optional, but recommended)

Cardiopulmonary Resuscitation (CPR)

If my heart or breathing stops:

_____ **I want** CPR in all cases.

-OR-

_____ **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

-OR-

_____ **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.

Medical Interventions (Person has pulse and/or is breathing)

ALL patients will receive comfort measures.

_____ **Advanced Interventions:** Use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advance interventions as medically indicated. *Transfer to hospital if indicated; includes intensive care.*

-OR-

_____ **Limited Interventions:** DO NOT use intubation, advanced invasive airway interventions, or mechanical ventilation. Use medical treatment, IV fluids and cardiac monitor as indicated. *Transfer to hospital if indicated. Avoid intensive care.*

-OR-

_____ **Comfort Measures Only:** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction manual treatment of airway obstruction and non-invasive respiratory assistance as needed for comfort. *Only transfer to hospital if comfort needs cannot be met in current location.*

_____***I choose not to complete this section***

What's Meaningful to Me:

If I am nearing my death, I would like these things for support and comfort:

_____

_____

_____

_____

_____

If I am dying, I would like to be: (check one) ☐ at home ☐ in a hospital ☐ not sure

I am of the _____ faith, **and/or** consider myself _____

I am a member of the _____ faith community.

Please attempt to notify them at: _____

I want my health care providers to know these things about my religion or spirituality:

_____

_____

_____

My other wishes (e.g. environment, music, people, rituals):

_____

_____

_____

_____

_____

_____

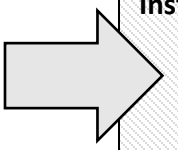
_____ ***I choose not to complete this section***

Preferences for Organ/Tissue Donation

In this section, you may, if you wish, state your instructions for: organ/tissue donation, autopsy, anatomical gift, and burial or cremation. By Michigan law, your patient Advocate and your family must honor your instructions pertaining to organ donation following your 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 the receiving institution. Burial or cremation preferences reflect my current values and wishes.



Instructions throughout this document:

- Put your initials next to the choice you prefer for each situation
- Cross out the choices you do not want, ~~like this.~~

Donation of my Organs, Tissue or Body

_____ After I die, I wish to donate any parts of my body that may be helpful to others.

_____ I have indicated this choice on my driver's license or state-issued identification card

_____ I am registered on my state's online donor registry

_____ After I die, I wish to donate ***only the following*** organs or tissue, if possible:
(name the specific organs or tissue): _____

_____

_____

_____ I want my body to be donated to an institution of medical science for research or training purposes.

I have made arrangements for this with the following institution: _____

_____

_____ I ***do not want*** to donate my organs, tissue or body

_____ ***I choose not to complete this section***

Preferences for Autopsy, Anatomical Gift and Burial/Cremation

Instructions throughout this document:

- Put your initials next to the choice you prefer for each situation
- Cross out the choices you do not want, ~~like this.~~
- Note: Elective autopsy may be at family's expense

Autopsy, Anatomical Gift, and Burial/Cremation Preference

_____ I ***would*** accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future healthcare decisions

_____ I ***would*** accept an autopsy if it can help the advancement of medicine or medical education

_____ I ***do not want*** an autopsy performed on me

My burial or cremation preference is: (initial only one)

_____ Burial _____Cremation

My pre-funeral arrangements have been made with: _____

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

_____ ***I choose not to complete this section***

Health Information Exchange (optional):

The Southwest Michigan Community plans to participate in a Health Information Exchange providing State-wide internet medical record storage service to medical providers only. There is no cost to you for this service. *Speak for Yourself, Plan Your Care*, your physician or attorney can file it for you. Not all hospitals are accessing this medical storage service at this time. It is recommended that you take a copy of this document with you to the hospital.

I consent to have my Advance Directive stored with the Health Information Exchange

Signature: _____ Date: _____

What Now?

Now that you have completed your Advance Directive, you should also take the following steps:

- Tell the person you named as your Patient Advocate, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future. Have your Patient Advocate sign the Patient Advocate form ***as soon as possible!***
- Talk to the rest of your family and/or close friends who might be involved if you have a serious illness or injury. Make sure they know your wishes and the names of your Patient Advocates(s).
- Make sure your wishes are understood and will be followed by your doctor or other health care providers.
- Keep a copy of your Advance Directive where it can be easily found (do NOT place it in a safe deposit box!).
- If you go to a hospital or a nursing home, take a copy of your Advance Directive with you and ask that it be placed in your medical record.

Distribute copies to any of the following, as appropriate: *(Photocopies of this document may be relied upon as though they were originals. If you are a DNR (Do Not Resuscitate, fill out and keep a copy of that form with this and also near the bedside, refrigerator, front door, or in your wallet/purse):*

- ☐ **Your advocates, and/or family**
- ☐ **Your physician**
- ☐ **Your local hospital**
- ☐ **Your attorney**
- ☐ **In the glove compartment**
- ☐ **With your clergy or faith community**
- ☐ **Keep a copy by the bedside, refrigerator and/or near the front door**

Review your Advance Directive every time you have an annual physical exam or whenever one of the "Five D's" occur:

1. **Decade** – when you start each new decade of your life.
2. **Death** – whenever you experience the death of a loved one.
3. **Divorce** – if you (or your Patient Advocate) experience a divorce or other major family change.
4. **Diagnosis** – if you are diagnosed with a serious health condition.
5. **Decline** – if you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

Healthcare Providers:

Contact Name: _____ Phone: _____

Address: _____

Contact Name: _____ Phone: _____

Address: _____