Check-List
for
ADVANCED DIRECTIVE

- √ Select a person you trust and ask them to be your patient advocate.
- √ Complete the *Durable Power of Attorney for Health Care* form.
- √ Ask your patient advocate to sign and date the *Acceptance by Patient Advocate* form.
- √ Complete the *Do-Not-Resuscitate* Declaration form, if applies.
- √ Provide a copy of the completed Advance Directive to:
  - Your Patient Advocate
  - Your Primary Care Provider
  - A family member
- √ Keep all documents together and put in a safe and accessible location.
- √ Always bring a copy of your Advance Directive to the hospital when you know you may be Admitted.
- √ Review your Advance Directive at least once a year.

CMU
CENTRAL MICHIGAN UNIVERSITY

1000 Houghton Ave,
Saginaw, MI 48602

1575 Concentric Blvd., Suite #1
Saginaw, MI 48604

Office Hours:
Monday - Friday
8:30 am to 5:00 pm

After Hours Call:
989-583-6800

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ADVANCED DIRECTIVES

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Frequently Asked Questions & Answers

Frequently Asked Questions and Answers About

ADVANCED DIRECTIVES

What is an "Advance Directive?"

- Advanced Directives are specific instructions that a person makes in advance that are intended to direct your medical care when you are not able to do so. They state your wishes about medical , surgical, and/or behavioral health when you are unable to speak for yourself.

Must I have an Advance Directive?

- No. Although there are many good reasons to have one, you do not need to have an Advance Directive. No family member, hospital, provider, or health plan can force you to have one. If you decide to write one, no one can tell you what it should say.

Are there different types of Advance Directives in Michigan?

- Yes. The Michigan legislature has authorized the use of a *Durable Power of Attorney for Health Care* in our state –and– a *Do-Not-Resuscitate* Declaration (DNR). **NOTE: A Living Will is not a legal document in Michigan.**

What is a "Durable Power of Attorney for Health Care?:

- It is a written document that allows you to give another person "Patient Advocate" the authority to make medical treatment and related health care decisions for you.

Who is eligible to have a Durable Power of Attorney for Health Care?

- You must be at least 18 years old and of sound mind.

What is the Physician's Role?

- Your physician and another physician determine whether you are able to participate in medical treatment decisions. If you have a written Durable Power of Attorney for Health Care and are determined unable to make medical treatment decisions, the physician obtains informed consent from the Patient Advocate.

When might you be unable to participate in medical treatment decisions?

- This could happen at any time. If you are in an accident and become unconscious or have a stroke. There might be long term or permanent loss from a disease such as Alzheimer's or dementia.

What is a Do-Not-Resuscitate (DNR) declaration?

- A Do-Not-Resuscitate (DNR) Declaration is a written document in which you state your wish that if your breathing and heartbeat stop, you do not want anyone to attempt to resuscitate you. If you have such a declaration in place, you may wear a Do-Not-Resuscitate Declaration bracelet that lets people know you do not want resuscitation. The DNR is valid in hospitals and other non-hospital settings such as nursing homes.

Must I be terminally ill to sign a DNR?

- No. You may be in good health but still not want to be resuscitated should your heart and lungs fail.

Can your Patient Advocate sign the form instead of you?

- If your Patient Advocate has authority to act, they can sign the form instead of you if you are determined unable to make medical treatment decisions.

Patient Advocate Designation for Health Care

I, _____
(print your name)

residing at _____
(street, city, state, zip code)

This document contains my wishes about my medical and mental health care. This patient advocate designation is only effective when I am unable to make my own medical decisions. I understand that if I change my mind, I may revoke my patient advocate appointment at any time.

Being of sound mind, I voluntarily choose the person named below to be my Patient Advocate and to make medical decisions for me when I cannot make them myself. I have talked to my advocate(s) and have provided them with a copy of this directive.

PATIENT ADVOCATE:

Name:_____ Relationship:_____

Address:_____City:_____State:_____Zip:_____

Telephone Number:_____

If the above person is not available, or cannot serve, I appoint the following person to be my **FIRST ALTERNATE PATIENT ADVOCATE:**

Name:_____ Relationship:_____

Address:_____City:_____State:_____Zip:_____

Telephone Number:_____

If the above person is not available, or cannot serve, I appoint the following person to be my **SECOND ALTERNATE PATIENT ADVOCATE:**

Name:_____ Relationship:_____

Address:_____City:_____State:_____Zip:_____

Telephone Number:_____

Patient Advocate Designation for Health Care

GENERAL GUIDELINES:
My Patient Advocate is authorized to make all decisions and to take all actions regarding my care, custody, medical 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. Employ and discharge physicians, nurses, therapists, and other health care providers, mental health professionals and other providers, and arrange to pay them reasonable compensation.
c. Consent to, refuse or withdraw on my behalf 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.

Specific Instructions Regarding Life-Sustaining Treatment: Specific care and treatment instructions that I have are listed below. I understand that **I <u>do not</u> have to *choose any specific instructions*** listed below regarding life-sustaining treatment and my general instructions will stand.

If I sign one of the instructions listed below, I direct that reasonable measures be taken to relieve pain and keep me comfortable.

Instruction 1:
I want doctors to do everything they think might help me. Even if I am very sick and I have little hope of getting better, *I want them to keep me alive for as long as they can regardless of the chances for recovery or cost of care.*

*The above statement reflects my desires:*_____
(signature)

Instruction 2:
I want doctors to do everything they think might help me, but, if I am very sick and I have little hope of getting better, such as in a coma or vegetative state that my doctor believes to be irreversible, *I do NOT want to stay on life support.* I understand this decision could or would allow me to die.

*The above statement reflects my desires:*_____

Instruction 3:
I want doctors to do everything they think might help me, but *(initial all that apply):*

_____ I do not want any person/doctor to attempt to resuscitate me if my heart and breathing should stop.
_____ I do not want a ventilator to pump air into my lungs if I cannot breathe on my own.
_____ I do not want a dialysis machine to clean my blood if my kidneys stop working.
_____ I do not want a feeding tube if I can't swallow.
_____ I do not want a blood transfusion if I need blood.

*The above statement reflects my desires:*_____
(signature)

Patient Advocate Designation for Health Care

Instruction 4:
I don't want any life support treatment.

*The above statement reflects my desires:*_____
(signature)

Instruction 5:
I want my Patient Advocate to decide for me.

*The above statement reflects my desires:*_____
(signature)

Instruction 6:
Other: _____

_____

*The above statement reflects my desires:*_____
(signature)

Specific Instructions Regarding Mental Health Treatment (OPTIONAL)

I authorize my Patient Advocate to make decision about the following treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care *(initial all that apply):*

_____ Outpatient therapy

_____ Psychotropic medication

_____ Admission to a hospital to receive inpatient mental health services as a formal voluntary patient. I have the right to give three days' notice of my intent to leave the hospital.

_____ Admission to a hospital to receive inpatient mental health services.

_____ Electro-convulsive therapy (ECT)

_____ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days' notice of my intent to leave a hospital if I am a formal voluntary patient.

*The above statement reflects my desires:*_____
(signature)

Patient Advocate Designation for Health Care

I understand that I may, but am not required to, designate a physician and/or mental health practitioner to certify in writing and after examining me that I am unable to give informed consent to mental health treatment. If any physician/practitioner that I designate is unable or unwilling to do so within a reasonable time, I understand that the examination and determination will be made by another physician or mental health practitioner.

I prefer that the following physician(s) and/or mental health practitioner(s) conduct the examination. ***NOTE: No designation is made if below is left blank):***

_____

Names of Physician(s) and/or Mental Health Provider(s)

Specific Instructions Regarding Religious Beliefs:
Some religions do not allow certain treatments or medicines, or a medical examination to determine ability to participate in making medical treatment decisions. If there are treatments that you do not want to have because of your religion, write them down below. Also if you require a determination of ability to make medical treatment decisions without a medical examination, describe (below) how that determination should be made.

_____

_____

_____

Specific Instructions Regarding Care of My Body After Death:
Initial the option below that reflects your choice regarding donation of your organs:

_____ I want to donate ALL of my organs

_____ I want to donate only the following organs: _____

_____

_____ I do NOT want to donate any of my organs

_____ I want my patient advocate to decide.

Other Instructions: _____

_____

_____

Patient Advocate Designation for Health Care

It is my understanding and intent that no one participating in my medical or mental health treatment shall be liable for following my instructions and the directions of my Patient Advocate that are consistent with my written directions.

This document reflects the decisions I want when I cannot make medical decisions as well as who I want to make the decisions for me. If I am unable to participate in making medical decisions and my Patient Advocate or Alternate Patient Advocate(s) are not able to act for me, I ask that the instructions I have given in this durable power of attorney for health care be treated as conclusive of my desires.

This document is signed in the state of Michigan. It is my intent that the laws pursuant to 1990 Public Act 312, MCL 700.496 & 1998 Public Act 368, MCL 700.5507 govern all questions about its validity, the interpretation of its enforceability and its provisions. I desire that it be applied to its fullest extent possible wherever I may be.

Signature:_____ Date (mm/dd/yyyy):_____

PRINT your name:_____

Address:_____ City:_____ State:_____ Zip:_____

WITNESSES SIGNATURES AND STATEMENT:

The two adult witnesses signed below are not my spouse, parent, child grandchild, brother or sister, and are not my presumptive heir or beneficiary at the time of witnessing. My witnesses are not my Patient Advocate(s). They are not an employee of a life or health insurance provider that provides me with coverage, or of a home for the aged where I reside, or of a community mental health services program or hospital that is providing mental health services to me, and are not my physician.

We witnesses, declare that the signature is made in the presence of the person who signed the designation of the durable power of attorney for health care above and that person as well as the witnesses are at least eighteen years of age. The person signed above appears to be making this designation voluntarily without duress, fraud, or undue influence and appears to be of sound mind.

_____	_____
Witness Signature Date (mm/dd/yyyy)	Witness Signature Date (mm/dd/yyyy)
_____	_____
PRINT Witness's name	PRINT Witness's name
_____	_____
Witness's telephone number	Witness's telephone number

Patient Advocate Designation for Health Care

ACCEPTANCE BY PATIENT ADVOCATE OF APPOINTMENT

I, _____
(print patient advocate's name)

agree to be the Patient Advocate for_____
(print patient's name)

I accept the patient choosing me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the patient as indicated in the durable power of attorney for health care, and as we have discussed verbally. I also understand and agree to the following:

1. This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding medical or mental health, as applicable. If this designation includes the authority to make an anatomical gift, the authority remains exercisable after the patient's death.
2. The patient advocate will not exercise powers concerning the patient's care, custody, and 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.
3. This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.
4. A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.
5. A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.
6. A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.
7. A patient may revoke his or her patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.
8. A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.
9. A patient advocate may revoke his or her acceptance of the patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.
10. A patient admitted to a health facility or agency has the rights enumerated in section 20201 of the public health code, 1978 PA 368, MCL 333.20201 of the Michigan Compiled Laws.

_____ _____
Patient Advocate's Signature Date (mm/dd/yyyy)