Otsego Memorial Hospital

Advance Directive/ Designation of Patient Advocate Form

ADVANCE DIRECTIVE/
DESIGNATION OF PATIENT ADVOCATE

for

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To my Family, Doctors, and All Concerned with my care:

These instructions express my wishes about my health care. I want my family, doctors, and everyone else concerned with my care to act in accord with them.

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

Designation of Patient Advocate (**to make decisions concerning my medical care in the event I am unable to make these decisions for myself**).

I designate the following person my Patient Advocate:

Patient Advocate's Name: ______________________________ ________________

Phone Number

Designation of Successor Patient Advocate(s)

I appoint the following person(s), in the order listed, to be my successor Patient Advocate if my Patient Advocate does not accept my appointment, is incapacitated, resigns, or is removed. My successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

Name: ____

Name: ____

My Patient Advocate or successor Patient Advocate may delegate his/her powers to the next successor Patient Advocate if he or she is unable to act.

My Patient Advocate or successor Patient Advocate may only act if I am unable to participate in making decisions regarding my medical treatment.

1. General Instructions

My Patient Advocate shall have the authority to make all decisions and to take all actions regarding my care, custody, and medical treatment including, but not limited to, the following:

a. Having access to, obtaining copies of, and authorizing the release of any current medical information necessary to make provisions and for decisions about my care.

b. Employ and discharge physicians, nurses, therapists, and any other health care providers, and arrange to pay them reasonable compensation.

c. Consent to, refuse, or withdraw for me any medical 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 instruction I have related to life-sustaining treatments.

2. Specific Instructions

This form will provide a guide for the person I choose to make decisions for me, in the event I am unable to make my own health care decisions. This person will be my patient advocate.
My Patient Advocate is to be guided in making those decisions for me based on my preferences regarding my care.

Some of my preferences are recorded below.

Cardiac Resuscitation	☐ I do want ☐ I do not want

Irreversible/ Terminal Condition		Reversible/ Shortterm Condition
☐ I do want ☐ I don't want	Mechanical Respiration	☐ I do want ☐ I do not want
☐ I do want ☐ I don't want	Feeding tubes	☐ I do want ☐ I do not want
☐ I do want ☐ I don't want	Kidney dialysis	☐ I do want ☐ I don't want
☐ I do want ☐ I don't want	Chemotherapy	☐ I do want ☐ I don't want
☐ I do want ☐ I don't want	Antibiotics	☐ I do want ☐ I don't want
☐ I do want ☐ I don't want	Intravenous fluids	☐ I do want ☐ I don't want

Specific Instructions: ____

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Regardless of my above choices, I understand that comfort measures to relieve pain will be provided, even pain that may occur because of withholding or withdrawing treatment.

3. 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:

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4. Upon my death

- ☐ In the event of my death I do not wish to donate tissues/organs
- ☐ In the event of my death I wish to donate
  - ☐ All organs
  - ☐ All tissues (bone, eye, other)
  - ☐ Only specific organs

  Please list:____

I understand that temporary life support may be required to maintain organ viability.

5. Patient Signature

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.

This document is signed in the State of Michigan. It is my intent that the laws of the State of Michigan govern all questions concerning its validity, the interpretation of its provisions, and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

Photocopies of this document can be relied upon as though they were originals.

I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn. I am at least eighteen years old and of sound mind.

I have the right to revoke or change this document at anytime by competing a new advance directive.

Signature___________________________________ Date: ___________________

Witness Statement and Signature

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, 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 or her Will at the time of witnessing, his or 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 or her, or an employee of a home for the aged where he or she resides and that I am at least eighteen years old.

WITNESSES:

Date:__________________ Signature ____

Date:__________________ Signature ____

Date:__________________ Signature ____

REAFFIRMED **It is recommended that this form be reviewed every two years.**

Date____________________ Signature ____

Date____________________ Signature ____

Date____________________ Signature ____

Date____________________ Signature ____

Acceptance of Patient Advocate

The Patient Advocate and any successor Patient Advocate must sign *this Acceptance before they may act as Patient Advocate*.

I agree to be the Patient Advocate for___________________________________. I accept the Patient's designation of 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 Designation of Patient Advocate, and as we have discussed verbally.

I also understand and agree that:

a. This designation shall not become effective unless the Patient is unable to participate in medical treatment decisions.

b. A Patient Advocate shall not exercise powers concerning the Patient's care, custody, and medical 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. This 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.

d. A Patient Advocate may make a decision to withhold or withdraw treatment which 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.

e. 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.

f. 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 treatment decisions are presumed to be in the Patient's best interest.

g. A Patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

h. A Patient Advocate may revoke his or her acceptance to the designation at 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 Public Health Code, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Law.

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

Name:____

Signature____

Home Phone_________________________ Work Phone _________________________

Successor PATIENT ADVOCATE

Name:____

Signature ____

Home Phone________________________ Work Phone _________________________

Successor PATIENT ADVOCATE

Name:____

Signature ____

Home Phone________________________ Work Phone _________________________