FOLLOWING YOUR HEALTHCARE WISHES

ADVANCE DIRECTIVE
AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Dickinson is now part of

Marshfield Clinic Health System

Instructions for Advance Directives and

Durable Power of Attorney for Health Care:

An Advance Directive:

- Tells your doctors and other health care workers what types of care you would like to have if you are not able to make your own medical decisions.
- Allows you to appoint an advocate who can make medical decisions for you if you are unable to make medical decisions for yourself.
- Protects you as the patient and protects the people who care for you.
- Permits an advocate to make medical decisions on your behalf when the document is activated.

To activate the advance directive, two doctors or a doctor and a psychologist would sign an additional form to say you no longer have the capacity to make your own healthcare decisions.

If you do not choose an Advocate:

- If you are too sick to make your own decisions and have not completed an advance directive, your doctors will ask your closest family members to make decisions for you. If your family members cannot make decisions for you or you need further care, then a judge may appoint someone to make decisions for you. There will likely be court/attorney fees associated with this which your family may be responsible for.

After this form is completed keep the original at home in a safe place. Share a copy of all five pages of the document with:

- Your Patient Advocate(s)
- Doctors
- Local hospital

An Advanced Directive is used when:

- You are unable to make your own decisions. Your plan in your advanced directive would be a guide for your advocate to follow. As long as you are capable of making your own decisions, you remain in control of your own medical care.

If you change your mind:

- Complete a new form and provide copies to everyone listed above.

If your Advocate has a name change, phone number or address change:

- Write/Type on a separate sheet of paper the updated information, attach it to your original document, and provide copies to everyone listed above.

If you want to make health care decisions that are not on this form:

- Write your choices on a piece of paper and keep the paper with this form.

You should review the form:

- Every 10 years.
- Every time you have a change in your health status.
- When you have a change in your home situation (example: new marriage, advocate's death).

If you have questions when completing this form:

- Bring it to your doctors, nurses, or social workers to answer your questions.
- You also have a right to see an attorney to complete this form.

Things to consider when completing form/Discussions to have with your Advocate:

- You have suffered a stroke and are alert, but can't communicate or care for yourself. If being fed by a spoon is no longer possible, do you want to be fed through a tube?
- You have dementia and live with family but don't recognize them anymore. Family has hired someone to stay with you while they work and the cost is hard on the family. You've been in the hospital with pneumonia three times this year. The next time you get pneumonia, do you want antibiotics for treatment or to be kept comfortable for end of life care?
- You are in a coma after a severe car accident. Your doctors do not think you will get better. Would you want to be on a long term ventilator far from your family, or would you like to be kept comfortable near your family for the rest of your life?

Please be sure to complete this document correctly. It must be witnessed:

- Hospital employees, your Doctor, and Doctor's office staff cannot be witnesses.
- Witnesses cannot be your immediate relatives (spouse, parent, child, grandparent, or sibling).
- You **MUST sign document in front of two witnesses** at the same time to make it a legal document. You and both witnesses need to all write the same date.
- Suggestions of where to find witnesses – example: bank, neighbors, church, work.

Designation of Patient Advocate and Directions for Health Care
Durable Power of Attorney for Health

Full Legal Name: ______________________________________ Date of Birth: _____________

This is an important legal document. You are encouraged to discuss it with your doctor and/or attorney if you have questions.

To my Family, Doctors and All Concerned with my care: These instructions express my wishes about my healthcare. I want my family, doctors, and everyone else involved with my care to review this document and follow my wishes as listed.

Appointment of Patient Advocate

I choose the following person as my primary Patient Advocate:

Patient Advocate's Name ____
Print

I choose the following person(s), in the order listed, as my alternate Patient Advocate if my Patient Advocate is unwilling or unable to serve as my advocate. My successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

Alternate Patient Advocate Name ____
Print

Alternate Patient Advocate Name ____
Print

My Patient Advocate or Alternate Patient Advocate may give his/her powers to the next Alternate Patient Advocate if he or she is unwilling or unable to serve as my advocate.

My Patient Advocate(s) may only act if I am unable to make healthcare decisions. **To activate the** Patient Advocate's ability to make decisions for me**, two doctors or a doctor and a psychologist would sign an additional form to say I no longer have the capacity to make my own healthcare decisions.**

1. General Instructions

My Patient Advocate will have the power to make any healthcare decisions I could have made for myself (example: care, custody, medical treatment) including, but not limited to:

a) Consent to, refuse or withdraw any healthcare. This may include care to prolong my life such as food and fluids by tube, breathing with the use of a machine, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis. I understand that these decisions could or would allow me to die. I have listed specific instructions for my Advocate to follow in the remaining part of this document.
b) Hire and fire healthcare providers, pay healthcare providers, ask for consultations or second opinions, and ask questions and get answers from healthcare providers.
c) Consent to admission or transfer to a health care provider or health care facility, including a mental health facility.
d) Get copies of my medical records.
e) Make an organ donation/anatomical gift of all or part of my body upon death in accordance with Michigan Public Acts 62 and 63 and Section 10102 of the Michigan Public Health code 1978 PA 368,MCL 333.10102.

2. Specific Instructions Regarding Life-Sustaining Treatment

Check the box to the **ONE** choice you most agree with. Please read this whole section before you make your choice. I understand that depending on the option I select the treatment plan could or would allow me to die.

- If I am so sick that I may die soon:

  □ Try all life support treatments that my doctors think may help. If the treatments **do not work** and there is little hope of getting better, **I want** to stay on life support machines.

  □ Try all life support treatments that my doctors think may help. If the treatments **do not work** and there is little hope of getting better, I **do not want** to stay on life support machines.

  □ Try all life support treatments that my doctors think may help but not these treatments:

  Mark what you **do not want**:

  □ Bipap/Cpap
  □ Feeding tube
  □ Trach
  □ Dialysis
  □ Long term ventilator
  □ Blood transfusion
  □ Medicine
  □ CPR
  □ Other:____

  □ I **do not want** life supportive treatments.
  □ I want my Patient Advocate to decide for me.

3. **Specific Instructions Regarding Admission to Nursing Home or Community Based Residential Facilities**

   My Patient Advocate may admit me to a nursing home or community-based facility for whatever care is needed for me be it short-term stay for recuperative care and/or respite care, or long-term care.

A. A Nursing Home:	□Yes	□ No
B. A Community-Based Residential Facility:	□Yes	□ No

4. **Specific Instructions Regarding Organ/Anatomical Donation (optional)**

   Put a check next to the one choice you agree with most.

   □ I want to donate my organs.

   Which organs do you want to donate?

   □ All organs

   □ Only these organs/parts: ____

   □ I do not want to donate my organs.

   □ I want my Patient Advocate to decide.

5. **Other Instructions I want to leave for my Patient Advocate:**

____

____

____

____

6. **Witness Statement and Signature**

   This document is to be treated as a Durable Power of Attorney for Heath 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 to be followed and that this document be treated as conclusive evidence of my wishes.

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 in agreement with my instructions.

It is my intent that the laws of the state where this document was signed govern all questions concerning its validity, the interpretation of its provisions and its enforceability. I also intend that it apply to the fullest extent possible wherever I may be located.

Photo copies 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 of age and of sound mind.

Your witnesses must be at least 18 years of age and see you sign this form. They cannot be your Patient Advocate, your healthcare provider/work for your healthcare provider, or be your immediate relative (Parent, spouse, child, grandparent, or sibling)

Your Signature ____ Date _______________

Printed Name ____

Address ____

By signing, I promise that _______________________________________ signed this form while I watched and appear to be of sound mind and under no duress.

Witness # 1

Signature ____ Date ________________

Printed Name ____

Address ____

Witness # 2

Signature ____ Date ________________

Printed Name ____

Address ____

7. Acceptance of Patient Advocate: *Your Patient Advocate must read and sign this form*

As the Patient Advocate for ___________________________________. I agree to the following:

- I will always act with the patient's best interests and not my own interests.
- I understand that I can only make decisions for the patient after the document has been activated because the patient has been found incapacitated.
- I will not be able to make decisions the Patient would not be allowed to make themselves.
- I do not have the power to stop a pregnant patient's treatment if it would cause her to die.
- I can make decisions to stop treatment and allow patients to die naturally if he or she made it clear that I can make that decision.
- I cannot be paid for the role as Patient Advocate but I can get paid back for the money I spend on the patients' medical expenses.
- The Patient can remove me as Patient Advocate whenever they want.
- I have the ability to revoke my acceptance of Patient Advocate.

If I am unavailable to act after reasonable effort to contact me, I give my authority to the persons the Patient has designated as successor Patient Advocates in the order selected. The successor Patient Advocate is approved to act until I become available to act.

Patient Advocate

Sign Name ____

Print Name ____

Address ____

Home Phone ______________________________ Cell Phone _______________________

Successor Patient Advocate

Sign Name ____

Print Name ____

Address ____

Home Phone ______________________________ Cell Phone _______________________

Successor Patient Advocate

Sign Name ____

Print Name ____

Address ____

Home Phone ______________________________ Cell Phone _______________________