# Start the Conversation:

# Making Your Health Care Wishes Known

Advance Directives

&

Durable Power of Attorney

For Health Care

SCHOOLCRAFT MEMORIAL HOSPITAL

# Durable Power of Attorney for Healthcare

I, _____, born on _____

(Print your full name) (Date of Birth)

am of sound mind and freely make these choices.

## Part 1: Naming of Patient Advocate(s)

- My primary patient advocate

Name: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

- If my Primary advocate is unable to serve, or cannot be found, I name (optional)

Name: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

In the event the primary and secondary named advocates are unable to serve, or cannot be located, I name (optional)

Name: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

# Part 2: Making Your Health Care Wishes Known

Use this section to state your preferences for health care.

**This section is not legally binding in the state of Michigan, but can serve as a helpful guide to your doctors and your Patient Advocate.**

- **Your Thoughts on Life**

When you think about the things that make your life worth living, which of the following apply to you: (pick one)

- My life is always worth living, no matter how sick I am
- My life is worth living only if I can do some of the things that are meaningful to me
- I am not sure

If you chose the second option, put an "X" next to all the sentences you most agree with:

- My life is worth living if I can:
  - Talk to family or friends
  - Wake up from a coma
  - Feed, bathe, or take care of myself
  - Be free from pain
  - Live without being hooked up to machines
  - Live at home (as opposed to a nursing home)
  - Other: _____
  - I am not sure
- If I am dying, I prefer to die: (pick one)
  - At home
  - At a facility (hospital, hospice, or nursing home)
  - I am not sure
- Is Religion or Spirituality important to you?

  Yes No

  If you have one, what is your religion? _____

- What should your doctors know about your religion or spirituality?

  _____
  _____
  _____
  _____
  _____

  - I am not sure
- Do you have any hopes for funeral or memorial service? You can include information on music, readings, or any other requests that you may have.

  _____
  _____
  _____
  _____
  _____

  - I am not sure
- Do you have any other wishes or thoughts on life that you would like to share? You can include information on how you would like to be treated, made comfortable, or any other requests that you may have.

  _____
  _____
  _____
  _____
  _____

  - I am not sure

# Your Wishes About Organ Donation

Your doctors may ask about organ donations after you die. Donating (giving) your organs can help save lives. Please tell us your wishes.

Put an "X" next to the choice you most agree with

- o I want to donate **all** my organs
- o I want to donate only these organs:

  _____

  _____

- o I **do not want** to donate my organs
- o I am not sure

- Do you have any additional thoughts on donating your organs? If so, please write them here.

  _____

  _____

  _____

  _____

  _____

# Making Your Wishes about Life Support Known

If you cannot speak for yourself, your Patient Advocate will make decisions about life support for you.

Most medical treatments can be attempted and then stopped if they do not help. It is important to talk to your health care providers, family members, and patient advocate about these choices.

If you are sick, your doctors and nurses will always try to keep you comfortable and minimize your pain. They will try to do what is best for you.

Please read all options below before making your choice. Select one option

If I am so sick that I am dying:

- I want doctors to attempt **all treatments** that they think might help, including life support, even if it may not help me get better

- I want doctors to do everything they think might help me, but if I am very sick and have little hope of getting better, I do **not** want to stay on life support

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

- I want my Patient Advocate to decide for me with the help of information from my doctors and thoughts on life

- I am not sure

- If you have specific preferences for treatments, please write here

  _____
  _____
  _____
  _____
  _____

In the event you are dying, your Patient Advocate can:

- Call in a Spiritual leader
- Enroll you in hospice care
- Decide if you die at home, if possible, or in the hospital
- Ensure your comfort and pain control

My other wishes for my health care:

_____
_____
_____
_____
_____
_____
_____
_____

# Your Instructions to Your Patient Advocate

If you would like to let your Patient Advocate make decisions that might allow you to die when you are very sick, please sign under the statement below.

- Michigan Law allows your Patient Advocate to refuse or stop life support treatments or CPR only if you give your Patient Advocate that power. If you would like to give your Patient Advocate that power, sign below. If you would prefer **not** to give your Patient Advocate that power, you may **skip** this section.

I want my Patient Advocate to make decisions about life support and treatments that would allow me to die when I am very sick. When making decisions, I want Patient Advocate to follow the guidelines I have provided.

_____

Sign your name here to give this power to your Patient Advocate

- **Show your Patient Advocate this form. Tell them the kind of medical care you want.**

## Part 3: Signatures

- Before this Advance Directive can be used, you must:
  - Sign form (next page)
  - Have 2 Witnesses sign form (next page)

- 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 assisted living)
  - Be **your** spouse, parent, child, or grandchild, or your brother or sister
  - Benefit financially (get any money or property) after you die
  - Work for your insurance company
- Your two 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 into it. Examples of witnesses could be neighbors, friends, church members.
- You **do not** need a notary or lawyer to complete this form

## 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 _____ signed this form while I watched. He/She appeared to be thinking clearly and were not forced to sign.

- **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)

## Part 4: Acceptance by Patient Advocate

- Your Patient Advocate must read and sign this form.
- 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 **two** doctors agree the patient is too sick to make 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 if they have made it clear that you can make that decision
    - You cannot be paid for your role as Patient Advocate but you can get paid back 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

By signing, I am saying that I understand what this document says and that I will be the Patient Advocate for _____ (Patient name)

_____

Patient Advocate Signature Date

_____

Second Patient Advocate Signature Date

_____

Third Patient Advocate Signature Date

## Advance Directives Final Checklist

Use this as a helpful guide to make sure that you have:

- 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 witnesses
- Signed the form in front of Witnesses
- Had your Patient Advocate sign the form

## What do I do next?

- ✓ Make copies of your form
- ✓ Give a copy to your health care provider
- ✓ Ask your health care provider to put the form in your medical record
- ✓ Give a copies to your Patient Advocates
- ✓ Give copies to family and friends
- ✓ Keep your copy in a safe and easy to find location
- ✓ Review the form once a year or as needed
    - ❖ If you **do not** agree with the information in your form, complete a new form
    - ❖ If you **do** agree, you can reaffirm the form in the space provided below

        - Date _____ Initial _____
        - Date_____ Initial _____
        - Date _____ Initial _____
        - Date _____ Initial _____

# Durable Power of Attorney for Healthcare

**Name:** _____

**Date of Birth:** _____

**Address:** _____

**Telephone:** _____

***Copies have been given to:***

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____
4. _____ Phone: _____
5. _____ Phone: _____
6. _____ Phone: _____
7. _____ Phone: _____
8. _____ Phone: _____
9. _____ Phone: _____
10. _____ Phone: _____

Original Document Date _____

Revised Document Date _____

Revised Document Date _____