

# Your Health Your Choice



## MY ADVANCE DIRECTIVE

### INTRODUCTION

This document expresses my preferences about my medical care if I cannot communicate my wishes or make my own health care decisions. I want my family, doctors, other healthcare providers, and anyone else concerned with my care to follow my wishes. For this reason, I give my patient advocate permission to share this document with doctors, hospitals, and health care providers that provide care to me. Likewise, health care providers with whom I have given this document may share it with other providers involved in my care. Any document created before this is no longer legal or valid.

My name: \_\_\_\_\_

My date of birth: \_\_\_\_\_

My address: \_\_\_\_\_

My city: \_\_\_\_\_ My zip code: \_\_\_\_\_

My telephone number: \_\_\_\_\_ My cell: \_\_\_\_\_

Date document completed: \_\_\_\_\_

Check One: I am:     Completing a new document     Updating a previous document     Unsure

### FREE ASSISTANCE

Do you need help in completing your advance directive? Do you have questions regarding the advance care planning process or forms?

Free assistance is available to help all Genesee County residents with advance care planning. Please contact any of the organizations below to be connected with a trained and certified advance care planning facilitator. There is no cost to use this service. To learn more about advance care planning, or to download the most current copy of the *Your Health Your Choice* advance directive, please visit our website at [www.yourhealthyourchoice.org](http://www.yourhealthyourchoice.org).



(810) 232-2228  
YHYC@flint.org  
Fax: (810) 232-3332



(810) 424-2270  
YHYC@genesys.org  
Fax: (810) 244-7426



(810) 262-2770  
YHYC@hurleymc.com  
Fax: (810) 262-9897



(810) 342-2546  
YHYC@mclaren.org  
Fax: (810) 342-4260

## MY CHOICE FOR MY PATIENT ADVOCATE

If I am unable to communicate my wishes and health care decisions due to illness or injury, or if my health care providers have determined that I am not able to make my own health care decisions, I choose the following person(s) to represent my wishes and make my health care decisions. My patient advocate must follow my health care instructions in this document and any other instructions I have given to them and must make decisions that are in my best interest.

I, \_\_\_\_\_ choose the person named below to be my primary Patient Advocate:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

If my primary patient advocate is not willing, able, or reasonably available to make a health care decision for me, I name as my alternative patient advocate (in the order listed):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**To act on my behalf, my patient advocate must read and sign the Patient Advocate's Acceptance on pages 9 and 10 of this advance directive document.**

# MY HEALTHCARE INSTRUCTIONS

## GENERAL INSTRUCTIONS

When I am unable to speak for myself, I want my Patient Advocate to be able to:

- Make choices for me about my medical care or services, such as testing, medications, surgery, hospitalization, and hospice care. If treatment has been started, he or she can keep it going or have it stopped depending upon my specific instructions (see section on next page) or my best interest (if I have not included instructions);
- Interpret any instructions I have given in this form (or in other discussions) according to his or her understanding of my wishes, values, and beliefs;
- Review and release my medical records and personal files as needed for my medical care;
- Participate in deciding arrangements for my medical care, treatment and hospitalization in Michigan or any other state, as he or she thinks appropriate.

### **Mental Health Advance Directive**

Michigan law gives individuals the right to complete an advance directive for their mental health treatment. Please contact your local community mental health agency (Genesee Health System) to learn of your rights regarding a mental health advance directive and for assistance in preparing the document.

## INSTRUCTIONS FOR LIFE SUSTAINING TREATMENT (OPTIONAL)

Life sustaining treatment is any medical device or procedure that increases your life expectancy by restoring or taking over a vital bodily function. This includes antibiotics and other medications, a breathing machine (ventilator), surgery, CPR, dialysis, and receiving food, water and other liquids through tubes.

With any choice I make regarding life-sustaining treatment, I understand that reasonable measures will be taken to keep me comfortable and free from pain as much as possible.

I give my patient advocate permission to make the following decisions regarding my preferences for my health care and request my health care providers honor them should I become unable to communicate or make my own choices. I understand that I can choose one of the three instructions regarding life-sustaining treatment below. If I choose one, I will 1) check the box next to my choice, 2) sign my name below my choice, and 3) cross out the choices I do not want. I understand I do not have to pick any of these choices if I do not wish to do so.

**Additional instructions pertaining to your choice may be outlined on the following page.**

**Choice #1**

I want to stop or withhold treatments that might be used to keep my body alive longer, if any of these conditions exist:

If it is reasonably certain that I will not recover my ability to interact meaningfully with my family, friends, and environment;

I am close to death;

I am terminally ill and these treatments would only artificially keep me alive longer;

I am in a coma and/or have severe, permanent brain damage and am not expected to recover;

The burdens of the medical treatment outweigh the benefits.

*This is my choice for treatment. I understand this decision could or would allow me to die.*

**Signature:** \_\_\_\_\_

**Choice #2**

I want my life to be prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes is irreversible. Once my doctor concludes I am permanently unconscious, I do not want life-sustaining treatment to be given or continued.

*This is my choice for treatment. I understand this decision could or would allow me to die.*

**Signature:** \_\_\_\_\_

**Choice #3**

I want my life to be prolonged as long as possible regardless of my condition, quality of life, or chances for recovery. I wish for life-sustaining treatments to be provided consistent with sound medical practice.

*This is my choice for treatment.*

**Signature:** \_\_\_\_\_

**ADDITIONAL INSTRUCTIONS (Optional):**

I want my patient advocate to follow the specific medical treatment instructions I have written and signed below. (These instructions may include your wishes regarding ventilators, dialysis, antibiotics, tube feedings, etc.) These instructions may complement in further detail or limit the General Instructions and Instructions for Life-Sustaining Treatment described on the preceding pages.

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My Signature \_\_\_\_\_

**DONATION OF MY ORGANS OR TISSUE:**

(Check one choice only and draw a line through the statements that you do not want.)

For more information on organ donation, contact Gift of Life Michigan: (866) 500-5801 or online at [www.giftoflifemichigan.org](http://www.giftoflifemichigan.org)

I wish to donate any organs or tissue if possible.

I wish to donate only the following organs or parts if possible (name the specific organs or tissue):

\_\_\_\_\_

I do not want to donate any organ or tissue.

**MY HOPES AND WISHES (Optional but Encouraged):**

An individual's responses regarding their hopes and wishes have been shown to improve the patient advocate's ability to guide the healthcare decision making process.

I want my patient advocate and loved ones to know my following thoughts and feelings:

1. The things that make life most worth living to me are:

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2. My thoughts and feelings about how and where I would like to die:

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3. To assist my loved ones and providers in understanding what I value, *I have checked the box that best describes how I feel about each statement:*

<b>Conditions I would or would not be willing to live with</b>	Acceptable	Somewhat worth living	Not worth living	Don't know
I can no longer recognize or interact with family / friends.				
I can no longer think clearly – I am confused all the time.				
I can no longer walk but get around in a wheelchair.				
My care needs require permanent nursing home residence.				
I am in severe pain most of the time.				
I am in severe discomfort most of the time (such as nausea, diarrhea, and shortness of breath).				
I need a feeding tube to keep me alive.				
I need a kidney dialysis machine to keep me alive.				
I need a breathing machine to keep me alive.				
I can no longer control my bladder/bowels.				
I need someone to take care of me 24 hours a day.				

4. If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (Family members, pets, rituals, prayers, music, etc.):

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5. Religious affiliation:

I am of the \_\_\_\_\_ faith, and am a member of \_\_\_\_\_ faith community in (city) \_\_\_\_\_.

I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

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6. Other wishes/instructions:

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**MAKING MY ADVANCE DIRECTIVE LEGAL**

**Patient Signature**

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

**Witness Statement and Signature**

I personally saw the above named individual 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 alternative appointed by the person signing this document.
- Not the spouse, parent, child, grandchild, brother or sister of the person signing this document.
- Not directly financially responsible for the person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee of a health care or insurance provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness signatures must be dated the same date as the patient.

**Witness Number 1:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Witness Number 2:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

## MY PATIENT ADVOCATE'S ACCEPTANCE

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

The person named above has asked you to serve as his or her Patient Advocate (or as an alternate or "back up" Patient Advocate).

Before agreeing to take on that responsibility and signing this form, please carefully read:

1. The previous "My Choice for My Patient Advocate" section of this advance directive which the named person has completed.
2. The *Your Health Your Choice* Advance Care Planning Guide, which provides important information and instructions.

**Most importantly, take the time to talk to the person choosing you as Patient Advocate so that you can gain the knowledge you need to allow you to make the decisions he or she would want made.**

If you are willing to accept the role of Patient Advocate, please read and sign the following statement. Your signature does NOT need to be witnessed or notarized.

I accept the patient's selection 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 "My Choice for Patient Advocate" form (or in other written or spoken instructions from the patient).

I also understand and agree that:

- 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 can make a decision to withhold or withdraw treatment which would allow the patient to die only if he or she has expressed clearly that I am permitted to make such a decision, and understand that such a decision could or would allow his or her death.
- e. 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.
- f. 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.
- g. 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.
- h. 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 mental health treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.
- i. I may revoke my acceptance of my role as Patient Advocate any time and in any manner sufficient to communicate an intent to revoke.
- j. A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Michigan Public Health Code, 1978 PA 368, MCL 333.20201

If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the person the patient has designated as the alternate Patient Advocate. The alternate Patient Advocate is authorized to act until I become available to act.

Patient advocate(s) acceptance signature/date must be on or after the patient and witness signatures/dates on page 7.

**Patient Advocate**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

**Alternative Patient Advocate**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

**Alternative Patient Advocate**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

## NEXT STEPS

Now that you have completed your health care directive, you should also take the following steps.

- Give your patient advocate a copy of your health care directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your patient advocate is, and what your wishes are.
- Give a copy of your health care directive to your doctors. Make sure your wishes are understood and will be followed.
- Keep a copy of your health care directive where it can be easily found and accessed.
- If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any of the “Five D’s” occur:
  - Decade – when you start each new decade of your life.
  - Death – whenever you experience the death of a loved one.
  - Divorce – when you experience a divorce or other major family change.
  - Diagnosis – when you are diagnosed with a serious health condition.
  - Decline – when you experience a significant decline or deterioration of an existing health condition especially when you are unable to live on your own.

A copy of your advance directive will be provided to Great Lakes Health Connect as an electronic record. Genesee County health providers, who are subject to strict privacy laws under HIPAA, may access these records only if they have a valid medical reason pertaining to your treatment. If you do not want your advance directive stored with Great Lakes Health Connect you may opt out by obtaining a form from their website at <http://gl-hc.org/opt-in-or-opt-out> or phoning them at 1-844-454-2443.

**Copies of this document have been given to:**

Primary Patient Advocate      Name: \_\_\_\_\_

Alternative Patient Advocate      Name: \_\_\_\_\_

Alternative Patient Advocate      Name: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Health Care Provider/Clinic

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

*If you choose to change your patient advocate or healthcare wishes, fill out a new advance directive and tell your patient advocate, your family, your doctor, and everyone who has copies of your old advance directive forms.*