Patient's Advance Directive

To my family, my physician, my clergy, my substitute decision-maker in the Durable Power of Attorney:

I, _____, being of sound mind, make this statement as an indication of my choice of medical care and as a directive to be followed if I become unable to participate in decisions regarding my health care. These instructions reflect my commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw treatment that serves only to prolong the process of my dying if I should be in an incurable or irreversible physical condition with no reasonable expectation of recovery.

These instructions apply if I am: (a) in a terminal condition; or (b) permanently unconscious; or (c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

If I am in any one of the conditions described above, I have indicated my wishes in regard to the following forms of treatment:
(Please check your choices)

Cardiac resuscitation	☐ I do want ☐ I do not want
Mechanical respiration	☐ I do want ☐ I do not want
Feeding tubes	☐ I do want ☐ I do not want
Kidney dialysis	☐ I do want ☐ I do not want
Chemotherapy	☐ I do want ☐ I do not want
Antibiotics	☐ I do want ☐ I do not want
Intravenous fluids	☐ I do want ☐ I do not want

(For additional instructions, add pages as necessary.)

These directives express my right to refuse treatment and they are instructions to my substitute decision maker as constituted in the Durable Power of Attorney instrument. I intend that my instructions be carried out unless I have rescinded them in a new written declaration or by a clear oral expression that I have changed my mind.

_____

(Signature) (Date)

_____

(Witness) (Date)

Witness

My designated decision maker is _____

whose address and current phone is _____

_____

The standard operating procedures of most health care facilities assume that you would want life-sustaining procedures unless you indicate otherwise.

Acceptance by Patient Advocate

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 in 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 interests.

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 Laws.

I understand the above conditions and I accept the designation as patient advocate for

_____

Dated: _____ Signed: _____

(Patient Advocate)

Dated: _____ Signed: _____

(Successor Patient Advocate)

Durable Power of Attorney for Health Care

I, _____ of _____ Michigan,
(Name) (City)

hereby appoint _____
(Patient Advocate)

residing at

_____,
(Patient Advocate Address)

as my attorney in fact (herein called patient advocate) with the following power to be exercised in my name and for my benefit, including, but not limited to, making decisions regarding my care, custody or medical treatment. This power of attorney has effect only if I become unable to participate in treatment decisions.

If the first individual is unable, unwilling or unavailable to serve as my patient advocate, then I designate

_____, residing at
(Successor Patient Advocate)

_____, to serve as my patient advocate.
(Successor Patient Address)

With respect to my personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:

(If any of the following do not apply, I may cross them out and place my initials next to the item.)

A. To have access to and control over my medical and other personal information.
B. To employ and discharge physicians, nurses, therapists and any other care providers, and to pay them reasonable compensation.
C. To give an informed consent or an informed refusal on my behalf with respect to any medical care; diagnostic, surgical or therapeutic procedure; or other treatment of any type or nature, including life sustaining treatments such as artificial nutrition and hydration.
D. To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care that I may need or to discontinue care that I am receiving.
E. To make decisions that could or would allow my death (except if I am pregnant).
F. My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care. Some of those preferences may be recorded below:

(Recording any of your preferences is optional*.)*

My wishes concerning care are as follows:

_____
_____
_____
_____

It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care not be liable for implementing the decisions of my patient advocate or honoring wishes expressed in this designation.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

This document is to be treated as a Durable Power of Attorney and shall survive my disability or incapacity.

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 construction of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

I voluntarily sign this Durable Power of Attorney after careful consideration. I understand its meaning and accept its consequences.

_____
(Signature) (Date)

_____
(Contract Number)

Witnesses:
(A witness shall not sign this Durable Power of Attorney unless the person appears to be of sound mind and under no duress, fraud or undue influence.)

Names and Addresses of Witnesses:

_____
(Witness 1 Name) (Witness 1 Address)

_____
(Witness 1 Signature)

_____
(Witness 2 Name) (Witness 2 Address)

_____
(Witness 2 Signature)

(A witness must be a disinterested individual and may not be the person's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, patient advocate, an employee of a life or health insurance provider for the patient, an employee of a health facility that is treating the patient, or an employee of a home for the aged.)