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 zipcode: _____

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.

Greater Flint Health Coalition
(810) 232-2228
YHYC@flint.org
Fax: (810) 232-3332

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

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

McLaren Flint
(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.

_____

_____

_____

My Signature _____

DONATION OF MY ORGANS OR TISSUE:

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

☐ 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:

   _____

   _____

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

   _____

   _____

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:*

Conditions I would or would not be willing to live with	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.):

_____

_____

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.):

_____

_____

6. Other wishes/instructions:

_____

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 Number 1:

Signature: _____ Date: _____

Name (*Print or Type*): _____

Address: _____

_____

Witness Number 2:

Signature: _____ Date: _____

Name (*Print or Type*): _____

Address: _____

_____

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

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.