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<tr>
<th>English</th>
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<tr>
<td>Henry Ford Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Let the health care team know if you need an interpreter. Henry Ford Health System provides language assistance services free of charge. For questions or additional information, email <a href="mailto:CommunicationAccess@hfhs.org">CommunicationAccess@hfhs.org</a></td>
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<td>Henry Ford Health System cumple con las leyes federales vigentes de derechos civiles y no discrimina con base en la raza, el color, el país de origen, la edad, la discapacidad o el sexo. Informe al equipo de atención médica si necesita un intérprete. Henry Ford Health System ofrece servicios de asistencia de idioma sin costo alguno. Si tiene alguna pregunta o necesita información adicional, envíe un correo electrónico a <a href="mailto:CommunicationAccess@hfhs.org">CommunicationAccess@hfhs.org</a></td>
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<td>يرجى إخبار فريق الرعاية الصحية إذا كنت تحتاج إلى مدرب فوري. يوفر نظام Henry Ford Health خدمات المساعدة اللغوية مجانًا. الاستفسارات أو المعلومات الإضافية، ارسل بريدًا إلكترونيًا إلى System <a href="mailto:CommunicationAccess@hfhs.org">CommunicationAccess@hfhs.org</a></td>
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<td>Henry Ford Health System ফেডারেল নাগরিক অধিকার আইন মেলে চলে এবং জাতি, বর্ণ, জাতীয় উপরাত্তি, বয়স, প্রতিবন্ধকতার বা নিষেধের ভিত্তিতে করে না। আপনার কোন দোভাবী প্রয়োজন থাকলে তা লেখ কেয়ার চিকে জানান। Henry Ford Health System বিশালমূল্য দোভাবী সহায়তা প্রদান করে। প্রশ্ন ও অতিরিক্ত তথ্যের জন্য এখানে ইমেল করুন: <a href="mailto:CommunicationAccess@hfhs.org">CommunicationAccess@hfhs.org</a></td>
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Advance Directives and Durable Power of Attorney for health care

This form lets you have a say about how you want to be treated if you get very sick.
This form has five parts. It lets you:

**Part 1: Choose a Patient Advocate.**
A Patient Advocate is a person who can make medical decisions for you if you are too sick or unable to make them yourself.

**Part 2: Make your own health care choices.**
This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

**Part 3: Sign the form.**
You must sign the form before it can be used.

**Part 4: Ask your Patient Advocate to sign.**
Your Patient Advocate must sign on page 11 to agree to be your Patient Advocate.

**Part 5: Have your Patient Advocate make mental health choices for you (optional).**
You must sign this page only if you want this option.

Write your name here:

_______________________________________________________________________________

Date of birth (month/day/year):

___________________ / __________ / __________

• If you only want a Patient Advocate named go to Part 1.
• If you only want to make your own health care choices go to Part 2.
• If you want both then fill out Part 1 and Part 2.

What do I do with the form after I fill it out and everyone has signed?

Share the form with those who care for you:
• Your Patient Advocate
• Doctors
• Nurses
• Social workers
• Family & friends

Keep a copy for yourself in a safe place.

What if I change my mind?
• You can change your mind at any time.
• Any spoken wish about a medical treatment must be honored by a Patient Advocate, even if it is different than what you put in your form.
• It is best to fill out and sign a new form.
• Tell those who care for you about your changes.
• Give the new form to your Patient Advocate and your doctors.

What if I have questions about the form?
Bring it to your doctors, nurses, social workers, Patient Advocate, family or friends to answer your questions.

What if I want to make health care choices that are not on this form?
• Write your choices on a piece of paper.
• Keep the paper with this form.
• Share your choices with those who care for you.

Fill out only the parts you want.
Always sign the form in Part 3.
Two witnesses need to sign on Part 3.
Part 1: Choose your Patient Advocate

The person who can make medical decisions for you if you are too sick to make them yourself.

Whom should I choose to be my Patient Advocate?
A family member or friend who:
• Is at least 18 years old
• Knows you well
• Can be there for you when you need them
• You trust to do what is best for you
• Can clearly tell your doctors about the decisions you made on this form

What will happen if I do not choose a Patient Advocate?
If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.
If your family members cannot make a decision, then a judge may appoint someone to make decisions for you.

What kind of decisions can my Patient Advocate make?
Agree to, say no to, change, stop or choose:
• Doctors, nurses, social workers
• Hospitals or clinics
• Medications, tests, or treatments
• What happens to your body and organs after you die

Your Patient Advocate may also:
• Make other decisions like whether or not to take you to a nursing home
• Look at your medical records to help make these decisions

Decisions your Patient Advocate can make regarding life support treatments (medical care to try to help you live longer)

CPR or cardiopulmonary resuscitation
Cardio = heart
Pulmonary = lungs
Resuscitation = to bring back

This may involve:
• Pressing hard on your chest to keep your blood pumping
• Electrical shocks to jump start your heart
• Medicines in your veins

Breathing machine or ventilator
The machine pumps air into your lungs and breathes for you. You are not able to talk when you are on the machine.

Dialysis
A machine that cleans your blood if your kidneys stop working.

Feeding Tube
A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

Blood transfusions
To put blood in your veins.

Surgery
Medicines

End-of-life care
If you might die soon, your Patient Advocate can:
• Call in a spiritual leader
• Decide if you die at home or in the hospital
Part 1: Choose your Patient Advocate

I want this person to make my medical decisions and be my Patient Advocate.

First name      Last name

Street address       City    State   Zip code

Home phone number    Work phone number    Cell phone number

If the first person cannot do it, then I want this person to make my medical decisions and be my Patient Advocate.

First name      Last name

Street address       City    State   Zip code

Home phone number    Work phone number    Cell phone number

You may write down your health care choices on this form. How do you want your Patient Advocate to follow these choices? Put an X next to the one sentence you most agree with.

☐ I want my Patient Advocate to work with my doctors and to use her/his best judgment. It is OK for my Patient Advocate to follow my health care choices on this form as a general guide.

Even though it is OK to follow my choices as a general guide, there are some choices I do not want changed:

__________________________________________

__________________________________________

__________________________________________

☐ I want my Patient Advocate to follow my health care choices on this form EXACTLY. I never want my Patient Advocate to change my choices, even if the doctors think this is not good for me.

To make your own health care choices go to Part 2 on the next page.
To sign this form go to Part 3. Your Patient Advocate must sign Part 4.
Part 2: Make your own health care choices

Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine. Write down your choices so those who care for you will not have to guess.

Think about what makes your life worth living.

My life is only worth living if I can:

*Put an X in the circle next to all the sentences you most agree with.*

- [ ] 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
- [ ] I am not sure

<< Or >>

- [ ] My life is always worth living no matter how sick I am.

If I am so sick that I may die soon:

*Put an X in the circle next to all the sentences you most agree with.*

- [ ] Try all life support treatments that my doctors think might 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 might 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 might help, except these (mark treatments you don’t want):
  - [ ] CPR
  - [ ] Medicine
  - [ ] Dialysis
  - [ ] Breathing machine
  - [ ] Feeding tube
  - [ ] Blood transfusion

<< Or >>

- [ ] I do not want any life support treatments.

<< Or >>

- [ ] I want my Patient Advocate to decide for me.

<< Or >>

- [ ] I am not sure.
Part 2: Make your own health care choices

If I am dying, it is important for me to be:

☐ At home  ☐ In the hospital  ☐ I am not sure

Is religion or spirituality important to you?

☐ No  ☐ Yes

If you have one, what is your religion? __________________________________________

What should your doctors know about your religion or spirituality?

________________________________________________________________________

________________________________________________________________________

Your Patient Advocate may decide to stop treatments and allow you to die.
Your Patient Advocate may make this decision ONLY if they think it is what you would have wanted.
Your Patient Advocate may never need to make this decision. But if they do, Michigan law will only let them stop treatment and let you die if your doctors know this is OK ahead of time.

Put an X in the circle next to all the sentences you most agree with.

☐ My Patient Advocate can decide to stop treatments and let me die.

☐ My Patient Advocate can NEVER decide to stop treatments and let me die.

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 in the circle next to all the sentences you most agree with.

☐ I want to donate my organs.
   Which organs do you want to donate?
   ☐ Any organ
   ☐ Only these organs: __________________________________________

☐ I do not want to donate my organs.

☐ I want my Patient Advocate to decide.
   If you let your Patient Advocate decide, he/she can make that choice after you die.

☐ I am not sure.
Part 3: Sign the form

Before this form can be used, you must:
• Sign this form
• Have two witnesses sign the form

Your witnesses must:
• Be at least 18 years of age
• See you sign this form

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 group home)
• Be related to you in any way
• Benefit financially (get any money or property) after you die
• Work for your insurance company

Sign your name and write the date.

____________________________  __________________________
Sign your name                              Date

____________________________  __________________________
Print your first name                     Print your last name

____________________________  __________________________
Street address                             City                     State                     Zip code

Date of Birth: (Month/Day/Year)

Witnesses need to sign their names on the next page.
Part 3: Sign the form

By signing, I promise that __________________ signed this form while I watched.

He/She was thinking clearly and was not forced to sign it.

Witness #1

_________________________ Date

Print your first name      Print your last name

Street address       City    State   Zip code

Witness #2

_________________________ Date

Print your first name      Print your last name

Street address       City    State   Zip code

Sign on the next page if you are named a Patient Advocate.

Share this form with your doctors, nurses, social workers, friends, family, and Patient Advocate. Talk with them about your choices.
Part 4: Acceptance by Patient Advocate

Your Patient Advocate must read and sign this form.
- 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 2 doctors agree that the patient is too sick to make his or her 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 treatments and allow the patient to die naturally IF he or she has made it clear that you can make that decision.
- You cannot be paid for your role as a Patient Advocate but you can get paid back for the money you spend on the patient’s medical expenses.
- The patient can remove you as Patient Advocate whenever he or she wants.
- You can remove yourself as Patient Advocate whenever you want.
- If the patient wants you to make mental health treatment decisions see Part 5.

By signing, you are saying that you understand what this document says and that you will be the Patient Advocate for ________________________________ (name of patient) who signed in Part 1 on __________________________ (date).

__________________________________________________________
Patient Advocate’s Signature Date

__________________________________________________________
2nd Patient Advocate’s Signature (if a second Patient Advocate is named) Date
Part 5: Mental Health Care Choice (optional)

Fill this part out only if you want to give your patient advocate the power to decide if you get mental health care.

Before my Patient Advocate can make mental health decisions for me 2 things must happen. First, a doctor and a mental health provider have to examine me and talk with me. Then they must write down that I can’t make my own decisions.

I can cancel my Patient Advocate’s power to make mental health decisions for me. But it won’t take effect for 30 days. It takes this long only for mental health care, but not medical care.

If my Patient Advocate agrees that I need to be in a mental health hospital, I still have the right to tell the hospital I want to leave. But I have to give the hospital 3 days’ notice.

This is a list of decisions your Patient Advocate can make about your mental health care.

*Put an X in the circle next to all the sentences you most agree with.*

**My Patient Advocate can decide for me about:**

☐ Getting mental health care at a clinic or someplace besides a hospital.

☐ Staying in a hospital to get mental health care as a voluntary patient. But I can still tell the hospital I want to leave in three days.

☐ Going to a hospital to get mental health care even if I don’t want to go.

☐ Getting medicines that may change how I feel, think or act.

☐ Electroconvulsive (electric shock) therapy

By signing this form, I agree to allow my Patient Advocate to make my mental health care decisions if two doctors say that I cannot make my own decisions.

(Sign your name here to give these powers to your Patient Advocate) 

Date

Date of Birth: (Month/Day/Year)