ADVANCE CARE PLANNING PACKET, WITH INTRODUCTION PAGE

Thank you for your interest in Advance Care Planning (ACP). This is an important step to having a say about your care.

THIS PACKET HAS THE FOLLOWING INFORMATION:

1. **What to Expect: Advance Care Planning (ACP)**
   This is a guide to help you complete your documents.

2. **Designating/Accepting Durable Power of Attorney for Health Care (DPOAH)**
   This is a legal document that gives permission for a specific person to speak for you when you cannot speak for yourself. Your decision maker is called a Patient Advocate.

3. **Treatment Preferences**
   This document is a helpful tool for your Patient Advocate. In this document you say what matters most to you. You can also share any specific treatment preferences you may have, such as cardiopulmonary resuscitation (CPR) or ventilator support.

4. **Completion Checklist**
   This will help you be sure these forms are completed correctly before sending them back to us.

INSTRUCTIONS TO RETURN:

- Return your document(s). Be sure all boxes are checked on your Completion Checklist. Call Advance Care Planning if you have questions or need help.

- RETURN YOUR DOCUMENT(S) IN ANY OF THE FOLLOWING WAYS:
  - Bring them to any Corewell Health location.
  - Email a copy of your document(s) to: advancecareplanning@corewellhealth.org
  - Fax 616.391.8965
  - Mail to: Advance Care Planning Department - MC041
    100 Michigan NE
    Grand Rapids, MI 49503

IF YOU HAVE QUESTIONS OR NEED HELP:

We want to help you to complete your document(s).
Phone: 616.774.7615 Available Monday - Friday 8 a.m. to 5 p.m.
Email: advancecareplanning@corewellhealth.org

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X27088 (9/24) (Spanish X27193) (Vietnamese X27194)
NOTE: X27088 is a packet which includes this Introduction Page.
This Introduction Page is never printed by its self.

What to expect: Advance care planning (ACP)

Advance care planning (ACP) is a process for you to reflect on your goals and values, to be able to make plans about current and future health care choices.

The information below will help you understand different types of ACP forms and how to complete them. If you need assistance, the Corewell Health Advance Care Planning team is here to help.

West Michigan
Phone **616.774.7615**
advancecareplanningwest@corewellhealth.org

Southwest Michigan
Phone: **269.983.8166**
advancecareplanningsouth@corewellhealth.org

Southeast Michigan:
947.522.1948
advancecareplanningeast@corewellhealth.org

Durable power of attorney for health care (DPOAH)

This form is used to designate a patient advocate, someone who can speak for you if you're unable. You will need two people to witness your signature on this form.

1. **Choose at least one decision maker.**
2. **Express any additional wishes regarding your care.**
3. **Give end of life authority.**
4. **Express mental health authority.**
5. **Sign the form in front of your two witnesses.**
6. **Have your witness sign the form right after you.**
7. **(Optional) Patient advocate signatures.**

1. Choose your decision maker.

You'll start by identifying the name of your patient advocate and we recommend a designating a minimum of two patient advocates.

A patient advocate is someone who can make decisions on your behalf if you are unable to. Their responsibilities may include:

- Honoring your preferences about care.
- Reviewing and releasing medical records.
- Arranging for medical care and treatment.
- Making decisions about your living situation.

The people you pick as patient advocate should:

- Be willing to take on this role and responsibility.
- Have knowledge of what your preferences are.
- Honor your preferences when making decisions for you, even if they disagree.
- Be someone who can make medical decisions in stressful situations.

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2. Communicate and share any additional wishes regarding your care.

- Share wishes regarding your care including any religious beliefs that prevent an examination by a doctor, licensed psychologist or other medical professional.
- Care or treatments that you would not want based on religious beliefs, for example blood products.

3. Give end of life authority

- Giving this authority allows your patient advocates to make decisions at the end of your life that would allow a natural death.
- For example, removing you from life support or enrolling you in hospice.

4. Give mental health authority.

- Giving this authority allows your patient advocate to make mental health decisions if you are unable to make your own decisions.
- This includes decisions about therapy, medications like antidepressants and hospital stays.
- You can also choose to delay your right to immediately revoke your patient advocate. If this box is checked, it means,
  - You are unable to make your own decisions and you are receiving mental health care.
  - You choose to cancel your patient advocate.
  - That choice would not go into effect for 30 days.
  - The waiting period is to give you a chance to stabilize and be sure that's what you want to do.

5. Wait to sign your document until you have your two witnesses with you.

Your witnesses must:

- Be at least 18 years of age.
- Not be the patient advocate or alternate patient advocate appointed by you.
- Not be related to you by blood, marriage or adoption.
- Not be listed to be a beneficiary of, or entitled to, any gift from your estate.
- Not be directly financially responsible for your health care.
- Not be a health care provider treating you or the facility you live in.
- Not be an employee of a health care or insurance provider treating you.

6. Witnesses sign the form right after you.

Who can help witness: Neighbors, friends, people in groups or faith communities you are a part of are all good options as witnesses.

7. Patient advocate signatures (optional).

- The form is complete without patient advocate signatures, however, it's best to have them sign, if possible
- If your patient advocate is not with you, they can sign at a later date. They will need to sign before they are able to make decisions on your behalf.

Treatment preferences

This form is used to capture what's important to you and any specific treatment preferences.

Your signature on this form does not require witnesses.

1. **Share what's most important to you (your goals and values).**
2. **Make your treatment decisions.**
3. **Identify your treatment preferences.**
4. **Sign.**

1. Share what's most important to you (your goals and values).

- It's important for us to know your goals and values. This helps us know you and what matters most.
- Is your focus on living as long as possible, quality of life or are they equally important?
- Note what living well means to you.

2. Make your treatment decisions.

There are two treatment decisions that you may share with your loved ones and health care team.

1. If a circumstance arises where you are no longer able to recognize your family or friends and you are not expected to recover that ability.

- This may occur with a brain injury that has occurred suddenly, for example a car accident or stroke.
- This could also happen with progression of an illness like dementia, Alzheimer's or liver failure.

Some people with a brain injury may need breathing support like a ventilator or tracheostomy.

2. Cardiopulmonary resuscitation (CPR): If your heart or breathing stops, your preference for cardiopulmonary resuscitation (CPR).

CPR facts: What you should know

This guide provides information about CPR (cardiopulmonary resuscitation) and how well it may work. You will need to talk with your doctors about what you might expect.

CPR has side effects that you should know about before you make a decision. Age and health make a difference. The doctor who knows you best can help you make your decision.

What is CPR?

CPR is an emergency procedure to try to restart your heart and breathing if they stop. CPR can include:

- Pressing on your chest,
- Mouth-to-mouth breathing or a tube to help get oxygen into your body, and/or
- Electrical shock and medicines.

Will CPR work for you?

Talk with your doctor about how well CPR would work for you.
Some things to consider:

- CPR works best if you are healthy and CPR is started immediately after your heart and breathing stops.
- CPR is less likely to be successful if you are older, weak, or living in a nursing facility.
- CPR does not fix or improve the reason that caused a person's heart and breathing to stop.

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The success of CPR

By "success," we mean living through CPR and being able to leave the hospital.

Of those adults who receive CPR in the hospital and live, up to 26% (or 26 out of 100) will leave the hospital alive.[1,2]

For those adults who are older, weak, and living in a nursing facility, CPR will be successful for 2% (or 2 out of 100) of individuals.[3]

What can happen after CPR

- If you receive CPR outside of the hospital, it requires transfer to a hospital to receive ventilator (breathing) support and care in an ICU (intensive care unit).
- If you survive, you may return to your current health, or you may have a decline in your physical or mental function.

Talk with your doctor about what you might expect.

Making a decision about CPR

What outcomes would you expect if CPR was started? What would your goals be?

If you want to try CPR, talk with your doctor about what results you might expect.

If you do not want to try CPR, talk to your doctor about how to document your decision by creating a medical order. Whatever you decide, you will always be offered appropriate care and make other health care decisions.

Tell your doctor and health care agent about your decision.

Questions I have for my doctor after reviewing this CPR information:

1. Girotra, S., Nallamothu, B. K., Spertus, J. A., Li, Y., Krumholz, H. M., & Chan, P. S. (2012). Trends in survival after in-hospital cardiac arrest. New England Journal of Medicine, 367:1912-20. doi:10.1056/NEJMoa1109148

2. Benjamin, E. J., Virani, S. S., Callaway, C. W., Chamberlain, A. M., Chang, A. R., Cheng, S., . . . Stroke Statistics Subcommittee. (2018). Heart Disease and Stroke Statistics-2018 Update: A Report from the American Heart Association. Circulation, 137(12), e67-e492. doi:10.1161/CIR.0000000000000558 [Cardiac Arrest information on pages e355-372]

3. Shah, M. N., Fairbanks, R. J., Lerner, E. B. (2007). Cardiac arrests in skilled nursing facilities: continuing room for improvement? J Am Med Dir Assoc. 8(3 Suppl 2): e27-31.

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3. Identify your end of life treatment preferences.

There are five treatment preferences that you may share with your loved ones and health care team.

1. Express your preference between wakefulness and comfort.

2. Hospice.

- **What is hospice care?**
  - Hospice is comforting care and nurturing support for patients and families who are coping with life-limiting illness.
  - Goals for hospice care are complete physical, emotional and spiritual comfort for the patient, education and support for the caregivers, and enhanced quality of life for all involved.
  - The goal is that each day, the patient feels as well as possible to enjoy what really matters to him or her and that each caregiver feels equipped and prepared to provide the best care possible.
- **What qualifies a person for hospice care?**
  - A diagnosis of a life-limiting illness for which cure is no longer the focus.
  - Certification by a physician as being appropriate for hospice care.
  - Patient's condition fits the Medicare requirements for the identified hospice diagnosis.
  - Patient chooses a course of treatment that is now focused on comfort, rather than cure.
  - Patient can give consent for hospice or have a representative who will give that consent on their behalf.
- **What are some signs that a person may be ready for hospice?**
  - A life-limiting illness is present and curative treatment is no longer being sought.
  - Increase in pain, nausea, breathing distress or other symptoms that are decreasing quality of life.
  - Physician efforts and treatments appear to be not making a difference or leading to more discomfort.
  - The individual is tired of the frequent hospitalizations and trips to the ED and wants to remain home and be comfortable.
  - He or she is emotionally withdrawn, sleeping more and less alert.
  - His or her physical activity has significantly decreased.
- **What are some signs that a family could benefit from hospice care?**
  - Family is physically and emotionally worn out from providing care.
  - There is a feeling that more help is needed in the home.
  - Feelings of uncertainty exist regarding how to best care for the patient and concern about what lies ahead.
  - There are decisions regarding the patient's care that may be made and there is confusion or conflict within the family regarding these decisions.

If you think hospice might be a good fit for you now, ask for a hospice informational visit.

3. Spiritual/Religious.

Share important preferences about your religion spiritual or faith-based beliefs.

Share things that bring you comfort or are important to you as you are nearing the end of your life.

4. Organ donation.

What is organ and tissue donation?

Organ donation is when an individual chooses to donate their organs and/or tissues legally. This can be done while a person is still living or upon their death with the agreement of the family.

Making a decision about organ donation

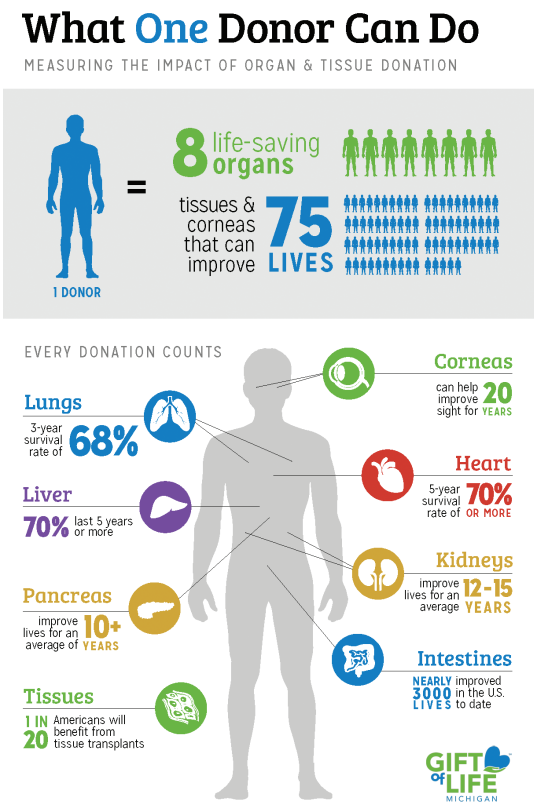
The decision to become an organ donor is a personal one. Speak with your doctor and family about your preferences and wishes around organ and tissue donation. You may change your mind at any time by contacting the gift of life registry and the Michigan Secretary of State.

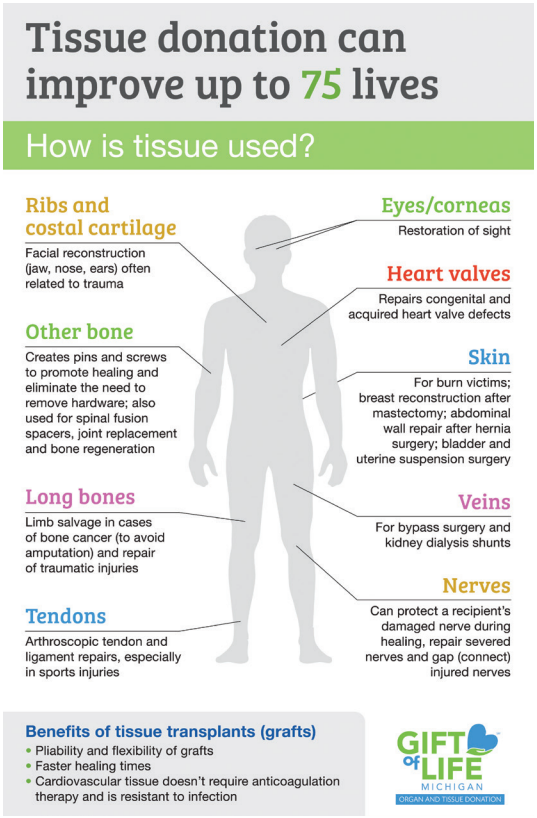
What you should know

- The number one priority of medical staff will be to save your life in the event there is a medical emergency.
- The emergency team is separate from those who work in the donation and transplantation of organs.
- Anyone can join the donor registry, regardless of lifestyle or health history.
- Only upon a person's death a medical official will determine what organs or tissue can be used to help others.
- While some things may prevent donation today, you may be a candidate for donation in the future.
- There are no age restrictions to join the registry. Minors may join the registry, with or without parental consent, however the final decision will be made by their parents until he or she turns 18 years of age.
- There is no cost to the individual, the family or the person's estate to register.
- The body will always be treated with dignity and respect. Nothing in the process would preclude any type of burial arrangement, including an open casket.

Facts about organ donation

- Organ donation may delay the time frame for a funeral to be held. In most cases the time extended ranges from 12 to 24 hours. Gift of Life will work closely with the funeral home, keeping them informed of a donor's status.
- By joining the Michigan Organ Donation Registry, you approve the use of all usable organs and tissues. However, you may complete a separate form indicating organs and tissues you are comfortable donating.
- Federal regulation requires each death in Michigan to be reported to Gift of Life. It is only at that time the Gift of Life will check the registry to confirm if an individual has documented their decision to help others.
- In the event that you have a "Do Not Resuscitate" order a ventilator will be used to keep the organs viable, although it is not required for tissue and cornea donation. If the DNR does not express your wishes to use a ventilator for organ donation, Gift of Life and the physicians will work with family on how to proceed. It is important to let your family know your wishes.





For more information on organ donation:

Gift of Life Michigan
866.500.5801
info@golm.org Email
giftoflifemichigan.org

Eversight
800.247.7250
eversightvision.org

5. Funeral/Burial

Let your loved ones know your preferences on burial or cremation.

People who care deeply about their impact on the environment can choose a green burial.

- Green (or natural) burials emphasize simplicity while offering you the opportunity to be buried in a meaningful way where your body decomposes naturally.
- Examples of green burial practices include, but are not limited to, the use of non-toxic embalming chemicals, biodegradable coffins, caskets and shrouds and natural grave markers, such as trees, shrubs, perennial flowers or rocks.

4. Sign the form: Your signature for this form does not require witnesses.

Reminder

Sharing your ACP information with your loved ones and your health care team is important. Making sure your documents are in your medical record ensures they are followed if you ever need them. You can also make copies and give to your patient advocates.

You may share a copy of your documents with Corewell Health in any of the following ways:

- Bring a copy to any Corewell Health location.
- Email **advancecareplanningwest@corewellhealth.org**
- Fax **616.391.8965**
- Call **616.774.7615** to request a postage paid envelope be sent to you.
- Mail to:
  Advance care planning department – MC041
  100 Michigan NE
  Grand Rapids, MI 49503

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ADVANCE DIRECTIVE: CHOOSING/ACCEPTING DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH)

NOTE:
- **This document was developed to meet the State of Michigan requirements for designating a Patient Advocate . It is not designed to replace the counsel of your attorney.**
- **If you are using the PDF fillable form, signatures must be signed by hand. Digital signatures are not allowed.**

CHOOSING/ASSIGNING AUTHORITIES TO MY PATIENT ADVOCATE(S):

My name (print) _____

Date of birth _____

WHO I CHOOSE AS MY PATIENT ADVOCATE:

FIRST CHOICE FOR PATIENT ADVOCATE:

I choose as my Patient Advocate:

Name of first choice Patient Advocate _____

Phone (_____) _____

BACKUP PATIENT ADVOCATE(S):

Second choice for Patient Advocate:

If my first choice for Patient Advocate is not able, willing, or reachable to serve as my Patient Advocate, then I choose:

Name of second choice Patient Advocate _____

Phone (_____) _____

Third choice for Patient Advocate:

If both my first and second choice for Patient Advocate is not able, willing, or reachable to serve as my Patient Advocate, then I choose:

Name of third choice Patient Advocate _____

Phone (_____) _____

PATIENT ADVOCATE ROLE AS DPOAH:

- This DPOAH is only in effect if I become unable to participate in treatment decisions.
- Medicine or treatment intended to provide comfort or relief from pain will not be withheld or withdrawn.
- The people I choose are responsible to exercise power in my name and for my benefit.
- This DPOAH gives authority that includes (but is not limited to) making decisions regarding my care, custody or medical treatment.
- The people I chose are responsible to help me achieve my goals of care. This may include beginning, not starting, or stopping treatment(s). I understand that such decisions could or would allow my death.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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OVER →

CHOOSING/ASSIGNING AUTHORITIES TO MY PATIENT ADVOCATE(S): *(CONTINUED)*

COMMUNICATION WITH MY PATIENT ADVOCATE:

- I have talked to my Patient Advocate(s) and shared my wishes.
- I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life sustaining treatment.
- These are my preferences/wishes for my care (e.g., including any religious beliefs that prevent an examination by a doctor, licensed psychologist, or other medical professional).
  Note: *You do not have to complete this area*

_____

_____

_____

_____

☐ **I am giving my Patient Advocate(s) the ability to make decisions that might allow me to die. This includes having the authority to not start or stop life support or CPR.**

☐ **I am giving my Patient Advocate(s) the ability to make mental health decisions. This includes inpatient mental health services and psychotropic medicines. Psychotropic medicines are medicines that effect the mind, thoughts, feelings, and behaviors (for example medicines for depression).**

  ☐ **For mental health treatment decisions, I give up my right to immediately cancel my Patient Advocate choice. If I communicate (verbally or in writing) I want to cancel (revoke) my Patient Advocate choice, there will be a 30 day delay until it is canceled (revoked)."**

I UNDERSTAND:

- I do not intend for others (e.g., my family, the medical facility, doctors, nurses, other medical personnel involved in my care) to be liable for putting into action the decisions of my Patient Advocate or honoring wishes expressed in this authorization.
- After it is signed and witnessed, photocopies of this document will have the same legal force as the original document.
- This document is to be treated as a Durable Power of Attorney for Healthcare. It will survive my disability or incapacity.
- This Advance Directive includes Patient Advocate Acceptance and may also include Treatment Preferences.
- I can cancel (revoke) this Durable Power of Attorney for Healthcare at any time by letting my health care team know verbally or in writing.
- Once I sign this document, any other Durable Power of Attorney for Healthcare forms (complete before this one) are not valid.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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CONTINUED ON PAGE 3 ➔

CHOOSING/ASSIGNING AUTHORITIES TO MY PATIENT ADVOCATE(S): *(CONTINUED)*

I AGREE:

- I intend this authorization to be applied to the fullest extent possible wherever I may be.
- I am providing this designation of my own free will. I have not been told I am required to choose a Patient Advocate in order to receive care or to have care withheld/withdrawn.
- I am at least eighteen (18) years old.
- I am of sound mind.

MY SIGNATURE:

DATE _____

My signature _____

WITNESSES TO PERSON CHOOSING DPOAH SIGNATURE:

Note: **There must be two (2) witnesses for this choice to be valid.**

AS A WITNESS, I CERTIFY THAT I AM:

- At least eighteen (18) years of age.
- Not designated as a Patient Advocate for the above Person.
- Not related to the Person by blood, marriage or adoption.
- Not listed to be a beneficiary of, or entitled to, any gift from the above Person's estate.
- Not directly financially responsible for the above Person's health care.
- Not a health care provider treating the above Person.
- Not an employee of a healthcare/insurance provider treating the above Person.

Note: **There must be two (2) witnesses for this choice to be valid.**

I AM WITNESSING:

- The above Person assigning Power of Attorney to their Patient Advocate(s).
- The above Person is signing voluntarily and without duress, fraud, or undue influence.
- The above Person is at least eighteen (18) years of age.
- I understand the above Person to be of sound mind.

Witness One:

Witness One signature _____

Witness One (print) _____

Witness Two:

Witness Two signature _____

Witness Two (print) _____

INTERPRETING SERVICES:

I certify that I have interpreted, to the best of my ability, into and from the patient's stated primary language, everything said during the informed consent discussion.

TIME _____ ☐ AM ☐ PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

OVER FOR "RECORD ADVANCE DIRECTIVE: ACCEPTING ROLE OF PATIENT ADVOCATE DESIGNATED IN DURABLE POWER OF ATTORNEY FOR HEALTHCARE (DPOAH)" ➔

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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ACCEPTING ROLE OF DPOAH:

NOTE:
- **This document was developed to meet the State of Michigan requirements for designating a Patient Advocate . It is not designed to replace the counsel of your attorney.**
- **If you are using the PDF fillable form, signatures must be signed by hand. Digital signatures are not allowed.**

My name (print) _____

Date of birth _____

I UNDERSTAND AND AGREE THAT, ACCORDING TO MICHIGAN LAW:

- This DPOAH is only in effect if the Person becomes unable to participate in medical or mental health treatment decisions.
- I will not exercise powers concerning the Person's care, custody or medical/mental health treatment that Person (if he/she were able to participate in the decision) could not have exercised on his/her own behalf.
- If the Person is pregnant, I cannot make a medical treatment decision to withhold or withdraw treatment if that would result in the Person's death, even if these were the Person's wishes.
- I can make a decision to withhold or withdraw treatment, which would allow the Person to die. I can do this only if the Person has expressed clearly that I am permitted to make such a decision, and if the Person understands that such a decision could or would allow his/her death.
- 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.
- A Patient Advocate acts on behalf of the Person. They put the Person's best interests ahead of their own and have a duty to preserve good faith and trust. I will act as the Person's Patient Advocate. The Person may have expressed his/her treatment preferences or shown in past decisions (while he/she was able to participate in medical or mental health treatment decisions). These are presumed to be in the Person's best interests.
- The Person may cancel (revoke) his/her choice of me as Patient Advocate at any time and in any manner sufficient to express an intent to cancel (revoke).
- For mental health treatment decisions, the Person may waive (give up) the right to cancel (revoke) his/her choice of me as Patient Advocate. If such waiver is made, the Person's ability to cancel (revoke) (for mental health treatment decisions) will be delayed for 30 days after he/she expresses his/her intent to cancel (revoke).
- I may cancel (revoke) my acceptance of my role as Patient Advocate. This can be done any time and in any manner sufficient to express an intent to cancel (revoke).
- If an Individual is admitted to a health facility or agency, he/she has the rights enumerated in Section 20201 of the Michigan Public Health Code, Exercise of Rights by Individual's Representative 1978 PA 368, MCL 333.20201.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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ACCEPTING ROLE OF DPOAH: *(CONTINUED)*

Note: Refer to DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH) for the order Patient Advocate(s) are chosen.

FIRST CHOICE FOR PATIENT ADVOCATE:

- I am at least 18 years of age.
- I accept the role of Patient Advocate chosen by the Person above.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Person as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.
- If I am unable or unavailable to act after reasonable efforts to contact me, I delegate my Patient Advocate authority to the person designated as the Second Choice Patient Advocate. The following Patient Advocate(s) is/are authorized (in the order listed) to act until I become available to act.

DATE _____ **First Choice Patient Advocate signature** _____

First Choice Patient Advocate (print) _____

ALTERNATE PATIENT ADVOCATE(S):

SECOND CHOICE FOR PATIENT ADVOCATE

- I am at least 18 years of age.
- I accept the role of Patient Advocate chosen by the Person above.
- I am responsible to exercise power to benefit the Person named above and honor the choices and instructions they have given.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Person as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.
- If I am unable or unavailable to act after reasonable efforts to contact me, I delegate my Patient Advocate authority to the person designated as the Third Choice Patient Advocate. The following Patient Advocate(s) is/are authorized (in the order listed) to act until I become available to act.

DATE _____ **Second Choice Patient Advocate signature** _____

Second Choice Patient Advocate (print) _____

THIRD CHOICE FOR PATIENT ADVOCATE:

- I am at least 18 years of age.
- I accept the role of Patient Advocate chosen by the Person above.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Person as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.

DATE _____ **Third Choice Patient Advocate signature** _____

Third Choice Patient Advocate (print) _____

INTERPRETING SERVICES:

I certify that I have interpreted, to the best of my ability, into and from the patient's stated primary language, everything said during the informed consent discussion.

TIME _____ ☐ AM ☐ PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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ADVANCE DIRECTIVE: TREATMENT PREFERENCES

NOTE: · **This is a supplement to my "Advance Directive: Durable Power of Attorney for Health Care (DPOAH)".**
· **If you are using the PDF fillable form, signatures must be signed by hand. Digital signatures are not allowed.**

This Advance Directive document represents the Treatment Preferences for me

(print name) _____ Date of birth _____

The following are my preferences and values concerning my health care.

TODAY, IN MY CURRENT HEALTH:

Put an X along this line to show how you feel today, in your **current** health.

○———○———○———○———○

My main goal is to live as long as possible, no matter what. | **Equally important** | **My main goal of focus is on quality of life and being comfortable.**

AT THE END OF MY LIFE:

Put an X along this line to show how you feel if you were so sick **that you may die soon**.

○———○———○———○———○

My main goal is to live as long as possible, no matter what. | **Equally important** | **My main goal of focus is on quality of life and being comfortable.**

HOW I LIVE WELL:

What things are important to you in your life and what you need to be able to have a good day?	**Worth living, or acceptable**	**Somewhat worth living**	**Not worth living**	**Don't know or not sure**
If I can no longer recognize or interact with my family or friends, and there is no reasonable hope for improvement, my life would be:	☐	☐	☐	☐
If I am unable to think clearly and make my own decisions, and there is no reasonable hope for improvement, my life would be:	☐	☐	☐	☐
If I must be on a breathing machine for the rest of my life, my life would be:	☐	☐	☐	☐
If I cannot enjoy food and cannot feed myself or eat on my own ever again, my life would be:	☐	☐	☐	☐

CONTINUED ON PAGE 2 ➔

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DO NOT MARK BELOW THIS LINE — BARCODE ZONE — DO NOT MARK BELOW THIS LINE

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X24948 (9/24) – Page 1 of 4 (Spanish X25097) (Vietnamese X25098) (Arabic X30294) (Chinese X30296) (Albanian X30295)

X249488

HOW I LIVE WELL: *(CONTINUED)*

What things are important to you?	Worth living, or acceptable	Somewhat worth living	Not worth living	Don't know or not sure
If I am unable to talk and/or express my feelings, wants or needs, and there is no reasonable hope for improvement, my life would be:	☐	☐	☐	☐
If I am in severe pain that cannot be relieved most of the time, my life would be:	☐	☐	☐	☐
If I can no longer walk on my own and must rely on the use of a walker, a wheelchair, etc., and there is no reasonable hope for improvement, my life would be:	☐	☐	☐	☐
If I am unable to attend to my spiritual and/or religious needs ever again, my life would be:	☐	☐	☐	☐
If I am never again able to go out for social activities such as visiting friends, shopping and/or traveling, my life would be:	☐	☐	☐	☐
If I cannot financially contribute, or become a financial burden to my family, my life would be:	☐	☐	☐	☐
If I am never again able to take care of my hygiene needs, such as showering and/or toileting myself, my life would be:	☐	☐	☐	☐

Are there other important things you need to have a good day? _____

_____

_____

_____

POSSIBLE SITUATIONS:

There are decisions every person should think about. Imagine these scenarios:

SEVERE PERMANENT BRAIN INJURY:

If a situation arises where I am no longer able to recognize my family or friends and I am not expected to recover that ability:

- ☐ I want all possible efforts to prolong my life. Living as long as possible is what matters most.
- ☐ I want to try treatments. I will talk to my Patient Advocates and family about what my goals would be for continuing treatment.
- ☐ I want to receive treatment and care to keep me comfortable. How I live is more important than how long I live. I understand this may result in my death.
- ☐ I am undecided at this time.

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POSSIBLE SITUATIONS: *(CONTINUED)*

CARDIOPULMONARY RESUSCITATION (CPR):

If my heart stops beating, and I am no longer breathing, CPR may be started to try and restart it. CPR includes chest compressions to restart circulation, electrical shocks to restart a heartbeat, and inserting a tube through the mouth and into the trachea (intubation) to allow mechanical ventilation and artificial breathing. Without CPR, death will occur naturally.

If my heart or breathing stops, my preference for CPR is:

- ☐ I want CPR.
- ☐ I do not want CPR. I want to have a natural death.
- ☐ I am undecided at this time.

***NOTE:* This is NOT a Do Not Resuscitate (DNR) Order. A DNR order is needed by healthcare personnel to not start CPR. A DNR is a separate legal document. Talk with your healthcare provider if you would like a DNR Order.**

AT THE END OF MY LIFE:

WAKEFULNESS VERSUS COMFORT:

Near end of life there may be symptoms that prevent my comfort (e.g., pain shortness of breath, or nausea). My health care team will make every effort to safely manage my symptoms, while trying to maintain as much wakefulness as possible. As end of life nears, it may become difficult to maintain control of these symptoms AND still have normal wakefulness. This can be difficult for patients, families and the care team to know which is more important for you.

If this situation occurs:

- ☐ I value wakefulness over comfort. I am willing to tolerate physical discomfort to enable more wakefulness.
- ☐ I value comfort over wakefulness. I prefer to have my symptoms managed even if it means I may be sleepy and/or sedated.

My comments _____

_____

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AT THE END OF MY LIFE: *(CONTINUED)*

MY DECISION ABOUT HOSPICE IS:

☐ I would like to receive hospice services.
☐ I do not want to receive hospice services.
☐ I will allow my Patient Advocate to make decisions about hospice services.

I WANT MY HEALTHCARE PROVIDERS TO KNOW ABOUT MY RELIGION, SPIRITUAL PREFERENCES, OR FAITH BASED VALUES:

- My spiritual/religious belief(s) is/are _____
- I am connected with this faith group/congregation _____
- I want to try to have my personal clergy or spiritual support person(s) notified: ☐ No ☐ Yes
- I realize my religious beliefs and decisions may affect my physical, emotional or spiritual care. The information listed below is important to me (e.g., spiritual/religious rituals or sacraments, refusal of blood products, etc.) _____

_____

_____

_____

THINGS THAT BRING ME COMFORT, OR ARE IMPORTANT WHEN I AM NEARING THE END OF MY LIFE ARE _____

_____

_____

_____

MY ORGAN DONATION DECISION IS:

☐ I have a red heart on my driver's license.
☐ I want to donate my organs and tissue to help others.
☐ I will allow my Patient Advocate to make decisions about tissue and organ donation.
☐ I do not want my tissue or organs donated.

MY FUNERAL/BURIAL PREFERENCE IS:

☐ I would like to be buried. ☐ I would like to be cremated.
☐ I would like a "green burial". ☐ I would like _____
☐ I would like to be buried or cremated. I will let my next-of-kin decide.

DATE _____ My signature _____

INTERPRETING SERVICES:

I certify that I have interpreted, to the best of my ability, into and from the patient's stated primary language, everything said during the informed consent discussion.

TIME _____ ☐ AM ☐ PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

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ADVANCE CARE PLANNING (ACP) COMPLETION CHECKLIST

All pages of the document(s) below must be included in order to meet the State of Michigan requirements. If any document does not meet State of Michigan requirements, it cannot be honored by your health care team. Document(s) that do not meet the requirements will **not** be uploaded to your Medical Record. You will only be notified (through MyChart or by mail) if your document(s) is/are **not** uploaded.

BEFORE RETURNING YOUR DOCUMENT, DOUBLE CHECK YOU HAVE DONE THE FOLLOWING: ***NOTE: You must do all actions (for each check box) to meet State of Michigan requirements***

- ON THE "DESIGNATING/ACCEPTING DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH)" (X24949) DOCUMENT:

  In the "Designating/assigning authorities to my patient advocate(s)" section:

  - You should be the "Individual designating this DPOAH" and must:
    - ☐ Print your name (top of page 1)
    - ☐ Write your date of birth (top of page 1)
    - ☐ Sign your name (bottom of page 2)
    - ☐ Write the date above your signature (bottom of page 2)
  - Under "Witnesses to individual designating DPOAH signature", you must have two (2) people sign as witnesses to your designating a Patient Advocate.
    Note: Your witnesses cannot be family members (which includes family by marriage), health care workers or any individual you appointed to be your Patient Advocate.

    At top of page 3, check that both "Witness One" and "Witness Two":
    - ☐ Signed their names
    - ☐ Printed their names

  In the "Accepting role of DPOAH" section:

  - The acceptance signature(s) of your Patient Advocate(s) can be completed at a later date. Even if they are not available to sign now, your form is complete.

- ON THE "TREATMENT PREFERENCES" (X24948) DOCUMENT:

  You are the individual the Treatment Preferences are for and must:
  - ☐ Print your name (top of page 1)
  - ☐ Write your date of birth (top of page 1)
  - ☐ Sign your name (bottom of page 3)
  - ☐ Write the date above your signature (bottom of page 3)

MAKE A COPY OF YOUR COMPLETED DOCUMENT(S) FOR YOUR PERSONAL RECORD. SHARE IT/THEM WITH YOUR LOVED ONES AND HEALTH CARE TEAM.

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