DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____ ,
(print full name)

was born _____ , and I live at
(give date)

_____ .
(full address)

I am an adult, I am of sound mind, and I am voluntarily choosing to appoint

_____ ,
(name patient advocate)

living at _____ ,
(address)

to be my patient advocate.

If this person cannot or will not serve as my patient advocate, I designate

_____ ,
(name of 2nd choice)

living at _____ ,
(address)

to be my patient advocate instead.

I authorize and direct my patient advocate to make decisions for me regarding my care, custody, and medical treatment if I become unable to participate in medical treatment decisions for myself.

In making decisions for me, my patient advocate shall follow my wishes to the best of his or her knowledge and ability. This includes wishes I have expressed in writing and which I have not later rejected.

I give my patient advocate the following responsibilities:

- access to my medical records;
- authority to arrange medical services for me, including admission to a hospital, nursing home, or other care facility, and to pay for these services with my money;
- authority to consent to medical treatment for me, including the use of prescription medication, or to refuse treatment on my behalf.
- power to hire and fire medical personnel, including my attending physican.

PROTECTIVE MEDICAL DECISIONS DECLARATION

The following values history serves as a set of specific values-based directives for various medical interventions. It is to be used only in health care situations where I am unable to participate in making my own medical decisions and where my preferences concerning medical care are relevant. I direct that this values history and Protective Medical Decisions Declaration be made part of my medical record. A check and my initials beside each value indicates my beliefs and desires:

___ 1. Although I do not wish to suffer great pain, I do not authorize anyone to carry out any action with the purpose of ending my life.

___ 2. Since food and water are basic substances for physical existence, I authorize their withdrawal only when the following criteria have been met:

___ a. When, in the best medical judgment, my death will occur within a reasonable matter of hours or days, to be determined by my patient advocate;

___ b. When the intent is not to hasten my death but to provide additional relief from pain and suffering;

___ c. When my appointed advocate(s) have given written consent;

___ d. When it has been indicated on my medical record that the withdrawal of food and water does not mean the withdrawal of pain medication or other means of comfort care;

___ e. When my physical condition has deteriorated to the point where I am no longer able to assimilate hydration and nutrition.

___ 3. I authorize the administration of pain medication with the understanding that in attempting to control pain my life may be shortened by the use of narcotics.

___ 4. Under the conditions listed below, I wish to undergo cardiopulmonary resuscitation:

___ a. Once.

___ b. Twice.

___ c. As many times as necessary to restore heart and lung functions.

___ d. Never.

___ e. Other (explain).

___ 5. Under the conditions listed below I want to be placed on a ventilator:

___ a. In all circumstances.

___ b. For a trial period to determine effectiveness using reasonable medical judgment.

___ c. Under no circumstances.

___ 6. I want to have all medications used for the treatment of my illness continued provided such medication continues to be physically beneficial.

___ 7. I authorize the use of nasogastric (nasal) ___, gastric (stomach) ___, or other enteral feeding tubes ___, to facilitate my medical and/or comfort care.

___ 8. I authorize being placed on a dialysis machine under the following conditions:

___ a. Under all circumstances where such treatment would be beneficial to my physical condition.

___ b. For a trial period of _____ to determine effectiveness using reasonable medical judgment.

___ c. Under no circumstances.

___ 9. I wish to authorize the use of surgery.

___ 10. I wish to authorize the use of a blood transfusion.

___ 11. ___ I wish to authorize an autopsy to determine the cause of my death.
___ I do **not** wish to authorize an autopsy to determine the cause of my death.

___ 12. I want to be admitted to the Intensive Care Unit under the following conditions:

_____

_____

_____

_____

___ 13. If I am residing in a long-term care facility and experience a life-threatening change in my health status, I want 911 or other emergency personnel called in case of a medical emergency.

___ 14. If I have been diagnosed as being terminally ill (death will most likely occur within one year) I do not wish to be resuscitated by emergency personnel (911 or other emergency personnel).

___ 15. If I am pregnant at such time as I am unable to make my own medical decisions, all efforts must be undertaken to maximize survival for me and my unborn child.

___ 16. ___ I wish to donate my major organs.
___ I do **not** wish to donate my major organs.

___ 17. Upon my death, I want my body to be treated with respect.

SPECIAL PARAGRAPH: (optional)

By my signature below, I want to make it clear that my patient advocate is authorized to make a decision to withhold or withdraw treatment even when such decisions allow me to die.

_____

(Sign here if you wish to give your patient advocate this authority.)

Optional:

My specific wishes regarding treatment are:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I want my family, and my patient advocate to be protected by this document from any civil or criminal penalties for honoring my wishes as I have expressed them here, or as implemented by my patient advocate.

I retain the right to revoke this document at any time, and by any means.

Photocopies of this document, after it is signed by me and my witnesses, shall/shall not have the same legal force as the original.

(cross out one)(circle one)

_____

(date) (signature)

WITNESSES' STATEMENT
Durable Power of Attorney for Health Care

This document was signed by _____
(name)
in my presence. I believe that he/she is of sound mind, and has signed it voluntarily, without duress, fraud, or undue influence.

I further state that I am an adult, and that I will not receive any assets when he/she dies. I am not his/her spouse, parent, child, grandchild, sibling, physician, or patient advocate. Furthermore, I am not an employee of a life or health insurance provider for him/her, an employee of a health facility that is treating him or her, or an employee of a home for the aged where he/she resides.

signed by 1st witness: _____
(signature)

_____
(print full name)

address: _____

_____

signed by 2nd witness: _____
(signature)

_____
(print full name)

address: _____

_____

Acceptance of Durable Power

I, _____,

am over 18 years old. I have read the Durable Power of Attorney for Health Care signed by

_____ on _____.

I accept the responsibility to protect his/her wishes as expressed in that document when and if he/she becomes unable to participate in medical treatment decisions. I recognize the following legal requirements:

1. This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

2. I 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 on his or her own behalf.

3. 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.

4. I 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 I am authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient to die.

5. I shall not receive compensation for the performance of my authority, rights and responsibilities, but I may be reimbursed for actual and necessary expenses incurred in the performance of my authority, rights and responsibilities.

6. I 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.

7. A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

8. I may revoke this acceptance at any time and in any manner sufficient to communicate an intent to revoke.

9. 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 1978, being Section 333.20201 of the Michigan Compiled Laws.

I recognize that if _____ receives care in a hospital, or any other medical care facility, he/she will have certain rights which I must try to protect. These include:

1. Confidentiality of medical records.

2. The right to inspect medical records, or have me inspect them on his/her behalf if this Durable Power becomes effective.

3. The right to information regarding his/her medical condition, proposed treatment and prospects for recovery, and to have me receive that information after this Durable Power becomes effective.

4. Adequate and appropriate care.

5. The right to refuse treatment as provided by law.

6. Right to receive information regarding the facility's procedures for responding to patient complaints, and to have me receive that information or employ those procedures on his/her behalf if this Durable Power becomes effective.

7. Right to be free from physical and mental restraint, except as necessary to prevent injury.

_____ (Date)

_____ (Signature)

_____ (Printed Name)

_____

_____ (Full address)

"Stand-by"
Acceptance of Durable Power
by Secondary Patient Advocate

I, _____,

am over 18 years old. I have read the Durable Power of Attorney for Health Care signed by

_____ on _____.

If the primary patient advocate cannot serve, or revokes his/her acceptance, then I accept the responsibility to protect _____'s wishes as expressed in the DPOA when and if he/she becomes unable to participate in medical treatment decisions. I recognize the following legal requirements:

1. This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

2. I 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 on his or her own behalf.

3. 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.

4. I 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 I am authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient to die.

5. I shall not receive compensation for the performance of my authority, rights and responsibilities, but I may be reimbursed for actual and necessary expenses incurred in the performance of my authority, rights and responsibilities.

6. I 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.

7. A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

8. I may revoke this acceptance at any time and in any manner sufficient to communicate an intent to revoke.

9. 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 1978, being Section 333.20201 of the Michigan Compiled Laws.

I recognize that if _____ receives care in a hospital, or any other medical care facility, he/she will have certain rights which I must try to protect. These include:

1. Confidentiality of medical records.

2. The right to inspect medical records, or have me inspect them on his/her behalf if this Durable Power becomes effective.

3. The right to information regarding his/her medical condition, proposed treatment and prospects for recovery, and to have me receive that information after this Durable Power becomes effective.

4. Adequate and appropriate care.

5. The right to refuse treatment as provided by law.

6. Right to receive information regarding the facility's procedures for responding to patient complaints, and to have me receive that information or employ those procedures on his/her behalf if this Durable Power becomes effective.

7. Right to be free from physical and mental restraint, except as necessary to prevent injury.

_____
(Date)

_____
(Signature)

_____
(Printed Name)

_____

_____
(Full address)