Durable Power of Attorney for Healthcare Form

OSF Care Decisions is an Advance Care Planning program to help you plan for health care choices you may need to make in the future. Specially trained staff can help you identify what is important in your life, make a plan that meets your personal needs and record that information legally so that your wishes can be honored.

Before completing the Durable Power of Attorney for Healthcare form:

- Take time to read it carefully.
- Choose your Patient Advocate wisely. Will this person accept this duty willingly;
  - be able to make difficult decisions as you have instructed;
  - be involved in creating a clear plan that reflects your wishes and honors you when you most need them;
  - be comfortable with carrying out your wishes?
- Make sure your family understands your views and wishes. It is important that your family supports you, even if they do not fully agree with you.

This document will not give anyone control over your person until you become incapacitated, as defined by Michigan law.

This document will not give anyone control over your assets or finances.

Once you have completed this document:

- Keep the original in your possession.
- Make copies for your Patient Advocate(s), your physician(s), and your hospital.
- If you choose to create an optional Out of Hospital Do Not Resuscitate form, you should post it in a visible place in your home in the event you need to summon emergency medical personnel. Otherwise emergency personnel are required to provide life-sustaining treatments.

OSF Supportive Care

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Durable Power of Attorney for Healthcare Form

Name: _____ Birth Date: _____

Legal Address: _____

Current Address (if different than above): _____

Telephone: _____

Copies of this document are to be given to:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

I, _____ , born on _____ understand what I am attesting to, freely make these choices, and revoke all Power of Attorney documents completed prior to this one.

Part I - Appointment of Attorney for Healthcare

I name as my primary Patient Advocate:

Name: _____ Relationship: _____

Day phone: _____ Evening phone: _____ Cell phone: _____

Address: _____

City: _____ State: _____ Zip: _____

In the event my primary Patient Advocate is unable to serve, or cannot be located, I name:

Name: _____ Relationship: _____

Day phone: _____ Evening phone: _____ Cell phone: _____

Address: _____

City: _____ State: _____ Zip: _____

In the event neither of the above can be contacted, I name:

Name: _____ Relationship: _____

Day phone: _____ Evening phone: _____ Cell phone: _____

Address: _____

City: _____

State: _____ Zip: _____

Part II: Authority of Patient Advocate

In the event I am unable to make decisions myself, as determined by my physician and a second physician familiar with my condition, or my physician and a Clinical Psychologist, my Patient Advocate shall have the power to make all medical treatment decisions for me based on my most recent written or spoken instructions. If I have not provided clear instructions, my Patient Advocate is to make decisions based on my best interests and known wishes.

My Patient Advocate has the authority to:

- Consent or refuse treatment on my behalf; this includes but is not limited to tests, treatments and surgery,
- Determine if current treatments should be continued or stopped,
- Arrange for medical care,
- Arrange for mental health treatment,
- Admit me to, or transfer me to a hospital, nursing home, home nursing or hospice.
- Review and release my healthcare records as required for my continuing healthcare needs,
- Consent for organ donation as directed by me, even after my death.

My Patient Advocate is to interpret instructions I have given in this form according to his or her understanding of my wishes and values as we discussed.

When I am no longer able to make decisions for myself, my Patient Advocate shall have access to any of my medical records, if not previously authorized, upon signing an acceptance statement. This document shall serve as a medical records release under the Health Insurance Portability and Accountability Act (HIPAA).

My Patient Advocate(s) must accept this designation by signature. I have discussed my wishes with my intended Patient Advocate(s) and expect my family to cooperate in achieving my goals of care.

Name: _____ Birth Date: _____

Part III: Statement of Treatment Wishes/Living Will

In this section, you can state your preference for Life-Sustaining Treatments under certain conditions. Some examples of life-sustaining treatments are:

- **CPR (cardiopulmonary resuscitation)** - a process where trained persons may attempt to re-start your heart and provide breathing support. (You should know that the success rate for persons with advanced age and/or multiple health problems is very low even if done perfectly and with intensive support, and carries a burden of discomfort.)

- **Breathing machines (mechanical ventilation)** - a tube is inserted into your mouth and throat. A breathing machine pushes oxygenated air into your lungs. If you survive resuscitation efforts and improve, but are unable to be removed from a breathing machine, the tube must be removed from your mouth and inserted through your neck. When you are ready for discharge from the hospital, you will need to be moved to a long-term care facility equipped to handle you and your breathing machine. This could mean that you will have to move a hundred or more miles away from your home when you reside in Upper Michigan.

- **Kidney support (dialysis)** – Can be done locally as an out-patient, but may require transfer to another hospital if required for emergency situations in St. Francis Hospital.

- **Feeding tube or tubes for nutrition and hydration** - a tube is temporarily inserted through your nose and into your stomach, or surgically through your abdomen to your stomach to provide a more permanent access for water and food in a liquid form. Or, a long-term catheter is inserted into your arm or chest through which fluids and nutrients are delivered by intra-venous methods (IV).

- **Antibiotics & other medications** - there may come a time when treatment of a medical condition becomes more of a burden than a benefit, extending your life when your goals may include allowing a natural death. Medications, including antibiotics required to treat an infection, could cause discomfort and possible damage to your liver, kidneys, or other organs and make you sicker. You should discuss with your Patient Advocate, in advance of the need, whether you prefer oral, intra-muscular (IM), or intra-venous (IV) methods of medication delivery. Some drugs may only be given through the vein or in the muscle, which can increase discomfort. If you feel strongly about how you receive medications, you should inform your physician or Patient Advocate.

- **Recurrent hospitalizations** - you have the right to refuse admission to a hospital if you feel this would pose too much of a burden for you. You can be made comfortable at home, in an Adult Foster Care, a nursing care facility.

Name: _____ Birth Date: _____

Option A:

Think about each situation described below. Place your initials in the **ONE** box in each row across, which best describes how you would want to be treated. **If no boxes are checked, your advocate may make these decisions for you.**

If you are able to make your own healthcare decisions, YOU will be consulted.*	NO I would not want life sustaining treatments.	I'M NOT SURE. It would depend on the circumstances/ consider time-limited trials. (*See below.)	YES. I would want maximum life sustaining treatments.
If my physician reasonably determines that I am permanently unconscious, and there is little or no chance of recovery:	Initial here.	Initial here.	Initial here.
If I have a permanent, severe brain injury, or other disease that makes me unable to recognize my family or friends (for example severe head injury, stroke, or advanced dementia):	Initial here.	Initial here.	Initial here.
If I have a condition where other people must help me with daily needs like, bathing, toileting, or dressing, and I am unable to take food by mouth:	Initial here.	Initial here.	Initial here.
If I need machines to breath for me, and may need to be in bed for the rest of my life:	Initial here.	Initial here.	Initial here.
If I have a medical condition(s) that could make me die very soon, even with life-sustaining treatments.	Initial here.	Initial here.	Initial here.

**Time-limited trials can be offered to see how well you respond to treatment over a specific or recommended period of time, before continuing or stopping a treatment or medication.*

Option B:

I have lived a long life; as I move closer to a natural death, I want to be kept comfortable.
Initial here for Option B only: _____

Name: _____ Birth Date: _____

Pain and Symptom Management:

Sudden or Progressive illness can carry with it multitudes of distressing symptoms. You have the right to have your symptoms managed effectively using medications and treatments to remove all or part of your symptom burden. Symptoms may include but are not limited to pain, nausea, constipation, weakness, shortness of breath, fatigue, anxiety, depression, insomnia, excessive drowsiness and diminished sense of well-being. You should discuss any symptoms with your treating physician. In general what would you prefer? Choose one box for each line across:

	Yes.	I'm not sure.	No.
I want my pain and other symptoms managed to relieve distress.	Initial here.	Initial here.	Initial here.
I want my symptoms managed even if it means I will be drowsy and not interested in talking or eating.	Initial here.	Initial here.	Initial here.
I want my symptoms managed even if it requires a trial of sedation to the point I am no longer awake.	Initial here.	Initial here.	Initial here.

Other:

For example, whom would you want around when you are ill? Are there spiritual or religious practices or sacraments you require? What about funeral or burial plans? What about your pets? Where would you prefer to die? If you would not want to be cared for in a nursing or foster care home, how would you arrange for the extensive care you would need?

How strictly do you want your wishes followed?

Place your initials in the box next to the statement that reflects how strictly you want your Patient Advocate to follow your directives. Choose only **ONE**.

Initial here.	I want my directives as listed on this document to serve as a **general guide**. I understand situations may arise that are not included in this document, or that my Patient Advocate may decide different from what I have directed, if my Patient Advocate thinks after discussion with my treating physician, it is in my best interest.
Initial here.	I want my directives as listed on this document to be **followed strictly**, even if my Patient Advocate thinks it is not in my best interest.

I wish to be an organ donor: Yes No (circle one) Initial here: _____

I understand that organ donation may require continuance of life support or other treatments indicated to protect organ function.

Organ donation instructions: _____

Name: _____ Birth Date: _____

Part IV: Signature and Witnesses

Two people must see you sign this document. They both must be age 18 or older, or a legally emancipated minor. These witnesses, by Michigan Law, may NOT be:

- A spouse, parent, child, grandchild or sibling;
- Anyone who is named in your will, or may be a presumptive heir;
- A physician, an employee of a hospital, clinic, mental health facility or nursing home where you receive care;
- A Patient Advocate named in this document, or
- An employee of a life or health insurance company serving you.

Signature of Patient:

I am signing this document freely and understand the purpose of this document is to provide instructions regarding my healthcare choices, which may include treatments that might be withheld or withdrawn. I am at least 18 years of age or a legally emancipated minor.

Date: _____ Patient's Initials: _____

Patient's Signature: _____

Patient's printed name or chart label: _____

Legal address: _____

Temporary address (if indicated): _____

Signature of Witnesses:

I sign below as a witness and declare that this document was signed in my presence. The person named as patient appears to be of sound mind; is making this statement freely, without force, fraud, or undue influence; and appears to be a legal adult. I am not this person's parent, child, grandchild, brother or sister. I am not a physician or an employee of a healthcare provider, a community mental health program, or a home for the aged directly serving this patient at this time. I am not the Patient Advocate. I am not an employee of a life or health insurance company serving this person at this time. To my knowledge I will not benefit from a claim on this patient's estate.

Witness #1

Signature: _____

Printed Name: _____

Address: _____

Witness #2

Signature: _____

Printed Name: _____

Address: _____

Part V: Acceptance by Patient Advocate(s)

1. This designation shall not become effective unless the patient named in document is declared unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this Patient Advocate authority includes organ donation as described in Michigan Law, the authority remains active after the patient's death.

2. A Patient Advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if able to participate in the decision, could not have exercised in his or her 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 a pregnant patient's death.

4. 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 permitted to make such a decision, and that the patient understand that such a decision could or would allow the patient's death.

5. A Patient Advocate shall not receive compensation for performances of his or her duties. A Patient Advocate may be repaid for actual and necessary expenses incurred in the performance of his or her duties.

6. A Patient Advocate shall act in accordance with the standards of care which apply to trustees 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 or mental health treatment decisions are presumed to be in the patient's best interests.

7. The patient may cancel his or her choice of Patient Advocate at any time or in any manner sufficient to communicate intent to cancel.

8. A patient may give up his or her right to cancel the Patient Advocate named, as to the power to make mental health treatment decisions, and if such right is given up, his or her ability to cancel as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to cancel.

9. A Patient Advocate may cancel his or her acceptance of the duty at any time and in any manner sufficient to communicate intent to cancel.

10. A patient admitted to a health facility or agency has all rights as listed in Section 2021 of the Public Health Code, Act No. 368 of the Public Acts of 1978, Being Section 333.20201 of the Michigan Compiled Laws.

Name: _____ Birth Date: _____

Patient Advocate Acceptance:

I, (print your name here)_____ understand the above conditions, and I accept that I have been named as Patient Advocate or Successor Patient Advocate for (patient name here)_____

Signature: _____ Date: _____

I, (print your name here)_____ understand the above conditions, and I accept that I have been named as Patient Advocate or Successor Patient Advocate for (patient name here)_____ .

Signature: _____ Date: _____

I, (print your name here)_____ understand the above conditions, and I accept that I have been named as Patient Advocate or Successor Patient Advocate for (patient name here)_____ .

Signature: _____ Date: _____

This person was counseled by a professionally trained OSF St. Francis Hospital and Medical Group Advance Directives Facilitator, in accordance with Catholic Healthcare Religious and Ethical Directives and Michigan Law.

Name/Title of Facilitator: _____

Signature: _____

Date(s) of counseling: _____

Referred by: _____