



# “My Voice - My Choice”<sup>®</sup>

My Advance Directive

**Beaumont**



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**“My Voice - My Choice”<sup>®</sup> Advance Directive**  
**Patient Advocate Designation for Health Care Decisions**  
(Durable Power of Attorney for Healthcare)

Advance medical directives give you (adults 18 years of age and older) a way to tell others your wishes about medical treatments if you ever become so sick you cannot speak for yourself.

This form allows you to:

- name a legal spokesperson, your advocate, to make your medical decisions if you become so sick that you cannot make or communicate them yourself.
- document medical treatments you would or would not want if you become so sick that you cannot speak for yourself.

**Directions:**

1. Name an advocate and successor advocates. They must be at least 18 years old and agree in writing to be your advocate.
2. Decide what sort of life-sustaining treatments you would or would not want. Discuss these choices with your advocate, family and physicians. A values tool page is provided in this document to help guide you with decision making.
3. Complete the form, sign it and have it witnessed. There are restrictions on who can witness the document (see inside).
4. Make copies for your advocate, family and health care provider. Bring a copy to any hospital to which you are admitted.
5. Remember you can change or cancel this document at any time.

**“Use Your Voice Before You Lose Your Choice”**

**If you need additional information or have questions, please contact Family Matters Support Services at 313-593-7000 or visit [beaumont.org/advance-directives](http://beaumont.org/advance-directives).**

## Words You Need to Know

**Advance directive:** A written document that tells what a person wants or does not want if, in the future, he/she can't make his/her wishes known.

**Artificial nutrition and hydration:** When food and fluids are given through the vein (I.V.) or directly into the stomach by a feeding tube.

**Breathing machine/ventilator:** A tube placed down your throat or through your neck so that a respirator (ventilator) machine breathes for you

**Coma:** A state of unconsciousness from which the person cannot be awakened (this may be temporary, or may be permanent).

**CPR (cardiopulmonary resuscitation):** Treatment to try to restart a person's heartbeat and breathing which involves compressions to the chest, giving drugs through a vein, electrical shocks to the heart and artificial breathing through a tube.

**Electroconvulsive therapy/ECT:** Electric "shock" treatments to the brain used to treat some mental illnesses.

**Kidney machine/hemodialysis:** A machine that does the work of the kidneys when they have stopped working. Blood is removed from the body, run through the machine, then returned to the body over several hours, several times a week.

**Life-sustaining treatment:** Any medical treatment used to keep a person from dying. A breathing machine, CPR, and artificial nutrition and hydration are examples of life-sustaining treatments.

**Organ and tissue donation:** When a person permits his/her organs to be removed after death to be transplanted for use by another person.

**Pain control:** Medications used to decrease and manage pain. Side effects can make a person sleepy, and/or decrease blood pressure, heart rate or breathing.

**Psychotropic medication:** Medicines that affect mood, thinking or behavior used to treat mental illnesses.

**Terminal condition:** A condition caused by injury or illness that has no cure and death is inevitable.

**Transfusions:** Blood or blood products given through a vein.

**Whole body donation:** After death, donation of a person's whole body may be donated to a medical school to be used for education and research.

FILLING OUT THIS PAGE IS REQUIRED

This is a legal document. I am naming a Patient Advocate who will speak on my behalf if I become so sick that I cannot speak for myself. This form meets the legal requirements for the State of Michigan.

**Patient Advocate Designation for Health Care Decisions**  
(Durable Power of Attorney for Healthcare)

I, \_\_\_\_\_ (print your full name)  
living at \_\_\_\_\_ am of sound mind,  
and I voluntarily choose the following as my patient advocate and successor advocates to make care, custody, medical and mental health treatment decisions on my behalf. The authority given to my patient advocate is only exercisable if and when I am unable to participate in medical or mental health treatment decisions. I understand I can change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

**I appoint and designate the following person as my patient advocate:**

Name \_\_\_\_\_ Relationship (if any) \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Telephone \_\_\_\_\_

If that person is unable to act, resigns or is removed, I want this person to be my

**First successor advocate:**

Name \_\_\_\_\_ Relationship (if any) \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Telephone \_\_\_\_\_

If that person is unable to act, resigns or is removed, I want this person to be my

**Second successor advocate:**

Name \_\_\_\_\_ Relationship (if any) \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Telephone \_\_\_\_\_

FILLING OUT THIS PAGE IS OPTIONAL BUT ENCOURAGED

I will make my own decisions about my health care as long as I am able.  
 If the time comes when I am too sick to speak for myself, I ask that my patient advocate,  
 family and doctors honor the wishes I have chosen in this document.

**Instructions for my Patient Advocate**

Medical treatment affects quality of life. Much of the time it improves health or prevents decline. Sometimes, however, it can't help and only prolongs suffering. Not even the best medical treatment can keep a person alive forever. I want my advocate to know and honor my choices because these choices will affect what makes life meaningful to me and what I enjoy about living.

**Please read the following four (4) Choices and decide which ONE you agree with the most. Initial only that choice. The "Further Health Care Options" section allows you to give additional instructions for your advocate. Please discuss your wishes fully with your patient advocate, family and doctors.**

\_\_\_\_\_ **CHOICE 1: I have no objections to life-sustaining treatments.**

I do not object to being kept alive as long as possible by life-sustaining treatments that my doctors think may help. There is no time when I would wish for treatment to stop. For example, I would want to be kept alive even if I have a terminal illness and there is no cure for it, or if it is very unlikely that I would ever wake up from a coma or be aware of my surroundings again, or if it is very unlikely that I would ever be well enough to leave a hospital or nursing home.

**OR**

\_\_\_\_\_ **CHOICE 2: I object to life-sustaining treatments in certain circumstances.**

Please initial next to Choice 2 above and any statements below that you agree with.

I do not object to being kept alive as long as possible by life-sustaining treatments that my doctors think may help me except in the following circumstances:

- \_\_\_\_\_ I am terminally ill and there is no cure.
- \_\_\_\_\_ It is very unlikely I will ever wake up from a coma or be aware of my surroundings again.
- \_\_\_\_\_ It is very unlikely I will ever be well enough to leave a hospital or a nursing home.
- \_\_\_\_\_ I am very sick and have little hope of getting better.
- \_\_\_\_\_ I can't recognize or interact with my family or friends and there is little hope I will ever be able to do so again.
- \_\_\_\_\_ Other: \_\_\_\_\_

(Note: these choices don't prevent a short trial of treatments such as a breathing machine, feeding tube, or kidney machine to see if you will improve.)

**OR**

\_\_\_\_\_ **CHOICE 3: I object to all life-sustaining treatments in all circumstances even if my doctors think they might help me.**

**OR**

**\_\_\_\_\_ CHOICE 4: I want to leave all decisions to my advocate.**

I don't want to list specific instructions because it is hard to know what might happen to me in the future. Instead, I want my advocate to make decisions for me using what my advocate knows about my values and beliefs, and the burdens or benefits of my condition or its treatment.

**Further Health Care Options**

**In addition to the one choice I initialed in the section above, I also want my advocate to know and honor the following:**

**Please initial all the statements below that you agree with. Even if my doctors think these treatments would help me stay alive, even if the treatment might be needed only temporarily:**

- \_\_\_\_\_ I never want attempts to restart my heart or breathing if they stop. This is called "No CPR" or "DNR."
- \_\_\_\_\_ I never want transfusions or injections of blood or blood products.
- \_\_\_\_\_ I never want to be on a breathing machine.
- \_\_\_\_\_ I never want feeding tubes for nutrition and fluids.
- \_\_\_\_\_ I never want to be on a kidney machine.
- \_\_\_\_\_ I never want to live the rest of my life or to die in a nursing home if other appropriate arrangements are available.

**In addition:**

- \_\_\_\_\_ I want my pain controlled even if it makes me less aware.
- \_\_\_\_\_ I give my patient advocate the authority (which remains in effect after my death) to donate my organs and tissue for transplant into a sick person.
- \_\_\_\_\_ I give my patient advocate the authority (which remains in effect after my death) to donate my whole body for research or medical education.

**Do your religious beliefs affect the sort of care you would or would not want?**

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**Are there any other thoughts you want your patient advocate or family to be aware of?**

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**If you marked choice 2, 3 or 4 or initialed any Further Health Care Options, then you must read and sign the following statement.**

**I authorize my patient advocate to make decisions about life-sustaining treatments, even if those decisions could allow me to die. I specifically acknowledge and understand that these decisions could allow me to die.**

Your signature: \_\_\_\_\_

FILLING OUT THIS PAGE IS OPTIONAL

**Power Regarding Mental Health Treatment**

I authorize my patient advocate to make decisions concerning the following mental health treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care. (Initial all the statements that you agree with.)

- \_\_\_\_\_ Outpatient therapy.
- \_\_\_\_\_ My admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days' notice of my intent to leave the hospital.
- \_\_\_\_\_ My admission to a hospital to receive inpatient mental health services, other than as a formal voluntary patient.
- \_\_\_\_\_ Psychotropic medication.
- \_\_\_\_\_ Electro-convulsive therapy (ECT).
- \_\_\_\_\_ I give up my right to have a revocation of this document or my instructions effective immediately. If I revoke this document or my instructions on this page, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days' notice of my intent to leave a hospital if I am a formal voluntary patient.

**You must sign the following statement if you want your patient advocate to consent to forced medication or inpatient hospitalization except as a formal voluntary patient.**

**I want my patient advocate named in this form to have the power to consent to forced medications and to involuntary inpatient hospitalization.**

Your signature: \_\_\_\_\_

FILLING OUT THIS PAGE IS REQUIRED

This Patient Advocate Designation revokes any such Designation that I made before.

Photocopies of this form can be relied upon as though they were originals.

Your Signature

My signature below applies to all pages of this document. I want the people I selected in this document to be my patient advocate and successor.

I understand that this will let my patient advocate(s) make care, custody, medical and/or mental health treatment decisions for me when I am too sick to make or communicate such decisions myself.

I am making this decision because this is what I want, NOT because anyone forced me to.

Your signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

Print your name \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Statement Regarding Witnesses

I have chosen two adult witnesses who are not my spouse, parent, child, grandchild, brother or sister, and are not my presumptive heir or beneficiary at the time of witnessing. My witnesses are not my patient advocate(s). They are not my physician, or an employee of a health facility that is treating me, an employee of my life or health insurance provider or of a home for the aged where I reside, of a community mental health services program or hospital that is providing mental health services to me.

Witness' Declaration

We sign below as witnesses. This Patient Advocate Designation was signed in our presence. To the best of our knowledge the PERSON SIGNING APPEARS to be of sound mind and acting of his/her own free will (i.e., does not seem to be under duress, fraud, or undue influence).

\_\_\_\_\_  
Witness signature                      Date (mm/dd/yyyy)

\_\_\_\_\_  
Witness signature                      Date (mm/dd/yyyy)

\_\_\_\_\_  
Print witness name

\_\_\_\_\_  
Print witness name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Phone number

FILLING OUT THIS PAGE IS REQUIRED

Acceptance by Patient Advocate/s

I, \_\_\_\_\_ (patient advocate's name and successors) agree to be the patient advocate for \_\_\_\_\_ (patient's name).

I understand and agree to take reasonable steps to follow the desires and instructions of the patient.

I also understand and agree that:

- A. **This designation is not effective unless** the patient is unable to participate in medical or mental health treatment decisions, as applicable.
- B. **If this designation includes the authority to make an anatomical gift,** the authority remains exercisable after the patient's death.
- C. **A patient advocate shall not exercise powers** concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.
- D. **A patient advocate CANNOT exercise powers for a pregnant patient** to withhold or withdraw treatment or make medical treatment decisions that would result in the pregnant patient's death.
- E. **A patient advocate may make a decision to withhold or withdraw treatment** that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.
- F. **A patient advocate shall not receive compensation** for the performance of his or her authority, rights and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights and responsibilities.
- G. **A patient advocate 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 interest. 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 interest.
- H. **A patient may revoke his or her designation** at any time and in any manner sufficient to communicate an intent to revoke.
- I. **A patient may waive his or her right to revoke the designation** as to the power to make mental health treatment decision and, if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for up to 30 days.
- J. **A patient admitted to a health facility or agency has the rights** enumerated in MCLA 333.20201.

If I am unable to act after reasonable efforts to contact me, a successor patient advocate, in the order designated by the patient, shall act as a patient advocate until I become available.

\_\_\_\_\_  
Patient Advocate Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
First Successor Advocate Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Second Successor Advocate Signature

\_\_\_\_\_  
Date

## Helpful information about your Advance Directive

### “My Voice - My Choice<sup>®</sup>” Patient Advocate Designation for Health Care Decisions

Your Patient Advocate Designation for Health Care Decisions (Durable Power of Attorney for Health Care) and related forms are important documents.

- Keep the original signed documents in a secure but accessible place where others can find them.
- Give photocopies of the signed originals to your advocate, successor advocate(s), doctor(s), family, clergy and anyone else who might be involved in your health care.
- Bring photocopies of the signed documents with you every time you enter a nursing home, rehabilitation center or hospital.
- Be sure to talk to you advocate(s), doctor(s), clergy and family and friends, as applicable, about your wishes for medical treatment. Talk to them often, particularly if your medical condition changes or if your wishes change.
- Remember, you can always revoke a Patient Advocate Designation or change your mind and accept care you previously indicated you do not want. You can do this verbally, in writing or by any other available means.
- There is no expiration date of the document. It is wise to review it annually and/or if there are changes in your health status.
- If you want to change your documents after they have been signed and witnessed, you should complete new documents.
- Unless emergency personnel are aware of your documents and appropriate medical orders have been written, they will provide standard emergency care, including cardiopulmonary resuscitation (CPR).
- If you are in a hospital, rehabilitation center, nursing care facility or hospice, have the documents placed in your medical record. Talk with your attending physician and applicable specialists as soon as possible, so that appropriate medical orders are written relating to resuscitation and life prolonging treatment.
- If you are at home or in assisted living, and an ambulance is called because your heart beat or breathing stops, ambulance personnel must give CPR unless they receive a separate special order that complies with the “Michigan Do-Not-Resuscitate Procedure Act.” The order is signed by you or your patient advocate and is witnessed. Except in rare cases, your physician signs also. **Please find a wallet card for your use on the opposite page of this booklet.**

### What makes your life worth living?

This is a guide to help you begin thinking through the choices you will be making about life-sustaining treatments. It is not a part of the legal document but is here to help you think about, decide and discuss your wishes with your advocate.

The exercise on the following page will help you think about and express what really matters to you. For each row, check one answer to express how you would feel about the statements below. Think about your responses and make sure to explain your answers to your loved ones and health care providers.

Life is not worth living if:	Agree	Not sure	Disagree
I am no longer able to think clearly and make my own decisions.			
I can no longer walk, but get around in a wheelchair.			
I am no longer able to go out for social activities such as church, shopping and visiting others.			
I can no longer contribute to my family's well-being.			
I am in severe pain or discomfort most of the time.			
I rely on a feeding tube to keep me alive.			
I rely on a breathing machine to keep me alive.			
I need someone to help take care of me all of the time.			
I can no longer control my bladder/bowels.			
I live in a nursing home.			
I can no longer think clearly - I am confused all of the time.			
I can no longer talk and be understood by others.			
I can no longer recognize my own family members.			
I am a severe financial burden on my family.			
I would prefer to:	Agree	Not sure	Disagree
Be told the truth about my condition, no matter how 'bad' the news.			
Be told first rather than my family about my condition and treatment.			
Have my wish to refuse medical treatment be honored, even if it may shorten my life.			
Be kept free of pain, even if the dose of medicine would make me less aware.			
Have all treatments possible to keep me alive, even if I will never get better.			
Die at home rather than at a nursing home or hospital, if at all possible.			
Be allowed to die comfortably and be free of machines, if there is little hope for recovery.			

### “My Voice - My Choice”<sup>®</sup> Wallet Card

Please complete the wallet card. Write the names and phone numbers of your advocate(s).

<div style="display: flex; justify-content: space-between;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-size: small;">Cut along dotted line</div> <div style="width: 90%;"> <p><b>Advocate</b> Name: _____ Phone: _____</p> <p><b>Successor advocate 1</b> Name: _____ Phone: _____</p> <p><b>Successor advocate 2</b> Name: _____ Phone: _____</p> </div> <div style="writing-mode: vertical-rl; font-size: small;">Fold here</div> </div>	<p><b>“My Voice, My Choice”<sup>®</sup></b></p> <p><b>I have an Advance Directive.</b></p> <p>See back of this card for my advocate(s) information.</p> <p>_____</p> <p>Signature</p>
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**If you need additional information or have questions,  
please contact Beaumont Clinical Ethics at 313-593-7000.**

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