



# Advance Directives and Durable Power of Attorney for Health Care

*This form lets you have a say about how you want  
to be treated if you get very sick.*



Adapted with approval from the Creative Commons Attribution-Non Commercial-Share Alike License  
by Henry Ford Health System. Revised March 2014



This form has five parts. It lets you:



**Part 1: Choose a Patient Advocate.**

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

**Part 2: Make your own health care choices.**

This form lets you choose the kind of health care you want.



This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

**Part 3: Sign the form.**

You must sign the form before it can be used.



**Part 4: Ask your Patient Advocate to sign.**

Your Patient Advocate must sign on page 11 to agree to be your Patient Advocate.

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

---

Fill out only the parts you want. Always sign the form in Part 3.  
2 witnesses need to sign on page 10.

---

WRITE YOUR NAME HERE: \_\_\_\_\_

DATE OF BIRTH: (Month/Day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If you only want a Patient Advocate named go to [Part 1](#) on page 3.

If you only want to make your own health care choices go to [Part 2](#) on page 6.

If you want both then fill out [Part 1](#) and [Part 2](#).

---

Always sign the form in [Part 3](#) on page 9. Two witnesses need to sign on page 10.

---

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

Share the form with those who care for you:

- your Patient Advocate
- doctors
- nurses
- social workers
- family & friends

Keep a copy for yourself in a safe place.

## **What if I change my mind?**

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

## **What if I have questions about the form?**

- Bring it to your doctors, nurses, social workers, Patient Advocate, family or friends to answer your questions.

## **What if I want to make health care choices that are not on this form?**

- Write your choices on a piece of paper.
- Keep the paper with this form.
- Share your choices with those who care for you.

# PART 1

## Choose your Patient Advocate

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

### Whom should I choose to be my Patient Advocate?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can clearly tell your doctors about the decisions you made on this form

### What will happen if I do not choose a Patient Advocate?

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

If your family members cannot make a decision, then a judge may appoint someone to make decisions for you.

### What kind of decisions can my Patient Advocate make?

Agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medications, tests, or treatments
- what happens to your body and organs after you die

Your Patient Advocate may also:

- make other decisions like whether or not to take you to a nursing home
- look at your medical records to help make these decisions.

Your Patient Advocate will need to follow the health care choices you make in [Part 2](#).

# Part 1: Choose your Patient Advocate

---

Other decisions your Patient Advocate can make:

---

**Life support treatments** – medical care to try to help you live longer

- **CPR or cardiopulmonary resuscitation**

cardio = heart

pulmonary = lungs

resuscitation = to bring back

This may involve:

- pressing hard on your chest to keep your blood pumping
- electrical shocks to jump start your heart
- medicines in your veins

- **Breathing machine or ventilator**

The machine pumps air into your lungs and breathes for you.

You are not able to talk when you are on the machine.

- **Dialysis**

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

- **Feeding Tube**

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

- **Blood transfusions**

To put blood in your veins.

- **Surgery**

- **Medicines**

**End-of-life care** – if you might die soon, your Patient Advocate can:

- call in a spiritual leader
- decide if you die at home or in the hospital

**Show your Patient Advocate this form.  
Tell him/her what kind of medical care you want.**

# Part 1: Choose your Patient Advocate

---

## Your Patient Advocate

---

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

First name	Last name		
Street address	City	State	Zip code
Home phone number	Work phone number	Cell phone number	

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

First name	Last name		
Street address	City	State	Zip code
Home phone number	Work phone number	Cell phone number	

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

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

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

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

To make your own health care choices go to [Part 2](#) on the next page.

To sign this form go to [Part 3](#) on page 9. Your Patient Advocate must sign on page 11.

# PART 2

## Make your own health care choices

Write down your choices so those who care for you will not have to guess.

- **Think about what makes your life worth living.**

**My life is only worth living if I can:**

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

- talk to family or friends
- wake up from a coma
- feed, bathe, or take care of myself
- be free from pain
- live without being hooked up to machines
- I am not sure.

or

**My life is always worth living no matter how sick I am.**

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

- at home
- in the hospital
- I am not sure.

- **Is religion or spirituality important to you?**

- No     Yes

If you have one, what is your religion? \_\_\_\_\_

- **What should your doctors know about your religion or spirituality?**

\_\_\_\_\_  
\_\_\_\_\_

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.



## Part 2: Make your own health care choices

---

**Life support treatments** are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

---

Put an X next to the **ONE** choice you most agree with.  
Please read this whole page before you make your choice.

• **If I am so sick that I may die soon:**

Try all life support treatments that my doctors think might help.  
If the treatments **do not work** and there is little hope of getting better, **I want to** stay on life support machines.

or

Try all life support treatments that my doctors think might help.  
If the treatments **do not work** and there is little hope of getting better, **I do not want** to stay on life support machines.

or

Try all life support treatments that my doctors think might help  
but not these treatments.

Mark what you **do not** want:

- |  |   |
|--|---|
| <input type="radio"/> CPR                    | <input type="radio"/> Feeding tube      |
| <input type="radio"/> Dialysis               | <input type="radio"/> Blood transfusion |
| <input type="radio"/> Breathing machine      | <input type="radio"/> Medicine          |
| <input type="radio"/> Other treatments _____ |   |

or

**I do not want** any life support treatments.

or

I want my **Patient Advocate** to decide for me.

or

I am not sure.

## Part 2: Make your own health care choices

---

Your Patient Advocate may decide to stop treatments and allow you to die.

---

Your **Patient Advocate** may make this decision **ONLY** if they think it is what you would have wanted.

Your **Patient Advocate** may never need to make this decision. But if they do, Michigan law will only let them stop treatment and let you die if your doctors know this is OK ahead of time.

Please put an X in the **ONE** box you most agree with.

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

---

Your doctors may ask about organ donations after you die. Donating (giving) your organs can help save lives. Please tell us your wishes.

---

Put an X next to the one choice you most agree with.

I **want** to donate my organs.

Which organs do you want to donate?

Any organ

Only these organs: \_\_\_\_\_

I **do not want** to donate my organs.

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

I am not sure.

# PART 3

## Sign the Form

### Before this form can be used, you must:

- sign this form
- have two witnesses sign the form

### Sign your name and write the date.

---

Sign your name

Date

---

Print your first name

Print your last name

---

Street address

City

State

Zip code

Date of Birth: (Month/Day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Your witnesses must:

- be at least 18 years of age
- see you sign this form

### Your witnesses cannot:

- be your Patient Advocate
- be your health care provider
- work for your health care provider
- work at the place where you live (if you live in a nursing home or group home)
- be related to you in any way
- benefit financially (get any money or property) after you die
- work for your insurance company

---

Witnesses need to sign their names on the next page.

---

## Part 3: Sign the Form

---

Have your witnesses sign their names and write the date.

---

By signing, I promise that \_\_\_\_\_ signed this form while I watched.  
(name)

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

### Witness #1

---

Sign your name

Date

---

Print your first name

Print your last name

---

Street address

City

State

Zip code

### Witness #2

---

Sign your name

Date

---

Print your first name

Print your last name

---

Street address

City

State

Zip code

**Sign on page 11 if you are named a Patient Advocate.**

**Share this form with your doctors, nurses, social workers, friends, family, and Patient Advocate. Talk with them about your choices.**

# PART 4

## Acceptance by Patient Advocate

### Your Patient Advocate must read and sign this form.

- You should always act with the patient's best interests and not your own interests.
- You will only start making decisions for the patient after 2 doctors agree that the patient is too sick to make his or her own decisions.
- You will not be able to make decisions that the patient would not usually be able to make.
- You don't have the power to stop a pregnant patient's treatment if it would cause her to die.
- You can make a decision to stop treatments and allow the patient to die naturally IF he or she has made it clear that you can make that decision.
- You cannot be paid for your role as a Patient Advocate but you can get paid back for the money you spend on the patient's medical expenses.
- The patient can remove you as Patient Advocate whenever he or she wants.
- You can remove yourself as Patient Advocate whenever you want.
- If the patient wants you to make mental health treatment decisions see Part 5.

By signing, you are saying that you understand what this document says and that you will be the Patient Advocate for \_\_\_\_\_ (name of patient) who signed on page 9 on \_\_\_\_\_ (date).

---

Patient Advocate's Signature

Date

---

2nd Patient Advocate's Signature  
(If a second Patient Advocate is named)

Date

# PART 5

## Mental Health Care Choice (OPTIONAL)

FILL THIS PART OUT ONLY IF YOU WANT TO GIVE YOUR PATIENT ADVOCATE THE POWER TO DECIDE IF YOU GET MENTAL HEALTH CARE.

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

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

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

This is a list of decisions your Patient Advocate can make about your mental health care. Put a (X) in all the boxes you agree with.

My Patient Advocate can decide for me about:

- Getting mental health care at a clinic or someplace besides a hospital.
- Staying in a hospital to get mental health care as a voluntary patient. But I can still tell the hospital I want to leave in three days.
- Going to a hospital to get mental health care even if I don't want to go.
- Getting medicines that may change how I feel, think or act.
- electroconvulsive (electric shock) therapy

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

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

\_\_\_\_\_  
Date

Date of Birth: (Month/Day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



English	<p>English</p> <p>Henry Ford Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.</p> <p>Let the health care team know if you need an interpreter. Henry Ford Health System provides language assistance services free of charge. For questions or additional information, email <a href="mailto:CommunicationAccess@hfhs.org">CommunicationAccess@hfhs.org</a></p>
Spanish	<p>Español</p> <p>Henry Ford Health System cumple con las leyes federales vigentes de derechos civiles y no discrimina con base en la raza, el color, el país de origen, la edad, la discapacidad o el sexo. Informe al equipo de atención médica si necesita un intérprete. Henry Ford Health System ofrece servicios de asistencia de idioma sin costo alguno. Si tiene alguna pregunta o necesita información adicional, envíe un correo electrónico a <a href="mailto:CommunicationAccess@hfhs.org">CommunicationAccess@hfhs.org</a></p>
Arabic	<p>العربية</p> <p>يمتثل نظام Henry Ford Health System لقوانين الحقوق المدنية الفيدرالية السارية ولا يُمَيِّز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة أو الجنس.</p> <p>يُرجى إخبار فريق الرعاية الصحية إذا كنت تحتاج إلى مترجم فوري. يوفر نظام Henry Ford Health System خدمات المساعدة اللغوية مجانًا. للاستفسارات أو المعلومات الإضافية، أرسل بريدًا إلكترونيًا إلى <a href="mailto:CommunicationAccess@hfhs.org">CommunicationAccess@hfhs.org</a></p>
Bengali	<p>বাংলা</p> <p>Henry Ford Health System ফেডারেল নাগরিক অধিকার আইন মেনে চলে এবং জাতি, বর্ণ, জাতীয় উত্পত্তি, বয়স, প্রতিবন্ধকতা বা লিঙ্গের ভিত্তিতে বৈষম্য করে না। আপনার কোনো দোভাষীর প্রয়োজন থাকলে তা হেল্থ কেয়ার টিমকে জানান। Henry Ford Health System বিনামূল্যে দোভাষী সহায়তা প্রদান করে। প্রশ্ন ও অতিরিক্ত তথ্যের জন্য এখানে ইমেল করুন: <a href="mailto:CommunicationAccess@hfhs.org">CommunicationAccess@hfhs.org</a></p>