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Let’s have a conversation

Advanc e care planning begins with a conversation. Respecting Choices ® at Corewell Health in Southeast Michigan certi ed facilitators are available to guide you through the process. It involves sharing yo ur values and beliefs with your chosen patient advocate and doctor. Successful completion results in an advance directive

What is an advance directive?

The advance directive is a legal document that describes your speci c preferences for medical treatments in case you are unable to do this. Your advance directive, also called a durable power of attorney for health care, will only be used if you become so sick or injured you cannot communicate your wishes yourself. The advance directive starts with listing

Additional online worksheets

Learn more about Respecting Choices®

Durable power of attorney for health care – patient advocate designation

This is a legal document. I am naming a patient advocate who will speak on my behalf only if I cannot speak for myself or become unable to participate in making medical (as determined by my physician and one other physician or licensed psychologist) or mental health (as determined by my physician and mental health practitioner) decisions. My patient advocate has no authority to make decisions on my behalf at any time that I am able to participate in these decisions for myself. I authorize this document to be included as part of my medical record and given to my patient advocate and my health care provider as well as to successor advocates and health care systems where I receive care.

Patient ad vocate designation

I _____, living at _____
(patient's full name) (patient's address)

am over the age of 18, of sound mind and I voluntarily choose the following as my patient advocate or successor advocate to make health and care decisions for me if, and only if, I am unable to participate in these decisions myself. I understand I can change my mind at any time by communicating in any manner that this choice no longer re ects my wishes.

I choose the following person as my patient advocate

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone(s) home: _____ cell: _____ work: _____

Email: _____

If my Patient Advocate does not accept the appointment, is unwilling, unavailable or unable to act as my Patient Advocate then I want this person to be my:

First alter nate (successor) patient advocate:

Name: _____ relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone(s) home: _____ cell: _____ work: _____

Email: _____

Second alternate (successor) patient advocate:

Name: _____ relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone(s) home: _____ cell: _____ work: _____

Email: _____

*You may choose to name additional alternate (successor) patient advocates.

Patient signature

Must be signed and dated in the presence of two witnesses.

My signature below applies to all pages of this document, including 'Acceptance by patient advocate/ successor patient advocate' found on page 5. I want the people selected in this document to be my patient advocate and successor patient advocate(s). I am making this decision because this is what I want, NOT because I am being forced by anyone in anyway. I understand that I may revoke this patient advocate designation at anytime and in any manner that communicates my intent to revoke.

PATIENT Signature: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Power regarding life sustaining treatment-optional:

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my natural death.

Patient signature : _____ Date: _____

Witness statement

I declare that the person who signed this document signed it in my presence, and that they appear to be of sound mind and under no duress, fraud or undue in uence.

I am not:

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Respecting Choices® at
Corewell Health in Southeast Michigan – advance directive

My cultural or spiritual considerations

† I choose not to complete this section.

I want my loved ones and health care team to know the following about my religious, cultural or spiritual beliefs:

My religious, cultural or spiritual beliefs are:

_____

_____

_____

_____

As I am nearing my death, the following is important to me:

_____

_____

_____

_____

Upon my death, the following is important to me:

_____

_____

_____

_____

Additional comments:

_____

_____

_____

_____

Patient signature: _____ Date: _____

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Respecting Choices ®

Advance directive

Our promises to you:

- We will initiate the conversation.
- We will provide assistance with adv ance care planning.
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