



have
you had
the talk?

MEDICAL
INFORMATION

My name:

Date:

Birthdate:

Bloodtype:

Allergies:

In case of emergency contact:

Name:

Relationship to me:

Cell:

Home:

Work:

Name:

Relationship to me:

Cell:

Home:

Work:

Name:

Relationship to me:

Cell:

Home:

Work:

If I am unable to make decisions on my own behalf,

I have designated the following person to make them for me:

Name:

Street Address:

City:

State:

ZIP:

Cell:

Home:

Work:

My Durable Power Of Attorney can be found:

Last updated:

Last witnessed:

My Last Will and Testament can be found:

Last updated:

Last witnessed:



Other important documents can be found:

Diagnoses

Diagnosis	Date	Physician	Treatment

Surgeries/Medical Procedures

Surgery	Date	Surgeon	Hospital

Current Medications

Prescription	Date	mg	Frequency / Instructions	Treats (name condition)



Primary Physician

Name: _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____
Directions: _____

Specialist Physician

Name: _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____
Directions: _____

Specialist Physician

Name: _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____
Directions: _____

Other Medical Professional

Name: _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____
Directions: _____

Other Medical Professional

Name: _____
Street Address: _____
City, State ZIP Code: _____
Phone: _____
Directions: _____

STEP 2: Organize paperwork and put wishes in writing.



DURABLE POWER OF ATTORNEY FOR HEALTH CARE



I, _____, am of sound mind, and I voluntarily
PRINT OR TYPE YOUR FULL NAME

make this designation. I designate _____, my
FULL NAME OF PATIENT ADVOCATE

_____, living at _____ as
SPOUSE, CHILD, FRIEND, ETC. ADDRESS, CITY, STATE OF PATIENT ADVOCATE

my patient advocate to make care, custody and medical treatment decisions for me in the event I become unable to participate in medical treatment decisions. If my first choice cannot service, I designate

_____, my _____, living at
FULL NAME OF PATIENT ADVOCATE SUCCESSOR SPOUSE, CHILD, FRIEND, ETC.

_____ to serve as patient advocate.
ADDRESS, CITY, STATE OF PATIENT ADVOCATE SUCCESSOR

The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist. In making decisions for me, my patient advocate shall follow my wishes of which he or she is aware, whether expressed orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, and to arrange medical services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds. My patient advocate shall have access to any medical records to which I have a right.

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

SIGN YOUR NAME HERE IF YOU WISH TO GIVE YOUR PATIENT ADVOCATE THIS AUTHORITY

My specific wishes concerning health care are the following (if none, write "none"):

STEP 2: Organize paperwork and put wishes in writing.



DURABLE POWER OF ATTORNEY *continued*



I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for honoring my wishes as expressed in this designation or for implementing the decisions of my patient advocate.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Dated: _____ Signed: _____

Address: _____

NOTICE REGARDING WITNESSES

You must have two adult witnesses who will not receive your assets when you die (whether you die with or without a will), and who are not your spouse, child, grandchild, brother or sister, or an employee at the health care facility where you are a patient.

STATEMENT OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

Signed by Witness: _____
SIGNATURE

PRINT OR TYPE FULL NAME

Address: _____

Signed by Witness: _____
SIGNATURE

PRINT OR TYPE FULL NAME

Address: _____



ACCEPTANCE BY PATIENT ADVOCATE

- (A) This designation shall not become effective unless the patient is unable to participate in treatment decisions.
- (B) A patient advocate 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.
- (C) 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.
- (D) 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 authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.
- (E) A patient advocate shall not receive compensation for the performance or 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.
- (F) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and all 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 treatment decisions are presumed to be in the patient's best interests.
- (G) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.
- (H) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.
- (I) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act N. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

I understand the above conditions and I accept the designation as patient advocate for:

Dated: _____ Signed: _____

Provided by Hospice of Michigan, www.hom.org. This document is for your information and is not designed to replace the counsel of your attorney. REV. 10/04



DO-NOT-RESUSCITATE ORDER



DO-NOT-RESUSCITATE ORDER

I have discussed my health status with my physician, _____. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order is effective until it is revoked by me. Being of sound mind, I voluntarily execute this order, and I understand its full import.

DECLARANT'S SIGNATURE

DATE

TYPE OR PRINT DECLARANT'S FULL NAME

SIGNATURE OF PERSON WHO SIGNED FOR DECLARANT'S IF APPLICABLE

DATE

TYPE OR PRINT DECLARANT'S FULL NAME

Verbal order obtained from:

DATE

Dr. _____
PHYSICIAN'S NAME

By _____
RN'S NAME

PHYSICIAN'S SIGNATURE

DATE

TYPE OR PRINT PHYSICIAN'S FULL NAME

DATE

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

WITNESS SIGNATURE DATE

WITNESS SIGNATURE DATE

WITNESS SIGNATURE DATE

WITNESS SIGNATURE DATE

THIS FORM WAS PREPARED PURSUANT TO, AND IN COMPLIANCE WITH,
THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT.