My Voice: Designation of Patient Advocate

for:_________________________________________________
(Full Legal Name)

Oakwood Healthcare System
This is a legal document. It is intended to describe my desires for my care, custody, health care and medical treatment decisions in the event I am unable to speak for myself. I have also named a Patient Advocate who will speak on my behalf and carry out my choices. This form meets the legal requirements of the State of Michigan.

I will keep the original in a safe place and make copies to share with my Patient Advocate, Successor Patient Advocates, Physician and Healthcare Providers.

If my wishes change, I should update this form and notify my Patient Advocate, Successor Patient Advocates, Physician and Healthcare Providers.
My Voice: Designation of Patient Advocate

for:__________________________________________________________
(Full Legal Name)

I appoint and designate the following person as my Patient Advocate:

Patient Advocate’s Name: __________________________________________________________
Address: ________________________________________________________________________
City:_______________________________________State:_________Zip Code: ______________
Phone (home):____________________ (work):___________________ (other): ______________

Designation of Successor Patient Advocate(s)
If my Patient Advocate is unable to act, resigns or is removed, then I appoint and designate the
following person(s) in the order listed, as my Successor Patient Advocate(s). A Successor Patient
Advocate has the same powers and rights as my Patient Advocate. Whenever I use the term “Patient
Advocate” in this document, that terms also refers to a Successor Patient Advocate, when applicable.

Successor Patient Advocate’s Name: ______________________________________________________________
Address: ____________________________________________________________________________________
City:______________________________________________ State:____________ Zip Code: ________________
Phone (home):__________________________ (work):____________________ (other): ______________________

Successor Patient Advocate’s Name: ______________________________________________________________
Address: ____________________________________________________________________________________
City:______________________________________________ State:____________ Zip Code: ________________
Phone (home):__________________________ (work):____________________ (other): ______________________

• My Patient Advocate and Successor Patient Advocates are each 18 years of age or older.

• Any time when my Patient Advocate or Successor Patient Advocate is unavailable to act, my Patient Advocate or
  Successor Patient Advocate may delegate his/her powers temporarily to the next Successor Patient Advocate.

• My Patient Advocate can only act if I am determined to be unable to participate in making medical treatment
decisions. If I regain the ability to make decisions on my own, the powers of my Patient Advocate are suspended
  until I am again determined to be unable to participate in medical treatment decisions.

• In accordance with Michigan law, the determination of whether I am able to make my own medical treatment
decisions will be made by my attending physician and another physician, or by my attending physician and a licensed
  psychologist, unless my religious beliefs prohibit an examination.
(Complete this part only if religious beliefs prohibit an examination.)

My religious beliefs prohibit an examination to determine whether I am able to make my own medical treatment decisions. The determination should be made in the following manner: ____________________

____________________________________________________________________________________
____________________________________________________________________________________

I request, agree and understand that:

• My Patient Advocate has the power to make all decisions about my care and treatment, including the right to consent, refuse or withdraw care for me.

• My Patient Advocate can only make medical treatment decisions that I would be able to make on my own behalf.

• My Patient Advocate may have the authority to make anatomical gifts (see section “Additional wishes to my choice” on page 19).

• Anyone participating in my treatment is expected to follow the decisions of my Patient Advocate, as permitted by state law, as long as:
  • these decisions are consistent with my expressed wishes or
  • if I have not expressed wishes, the decisions are consistent with my best interests.

• For purposes of this document, the term “life sustaining treatment” includes, but is not limited to, breathing with the aid of a machine or receiving food, water and other liquids through tubes.

• If no Patient Advocate is available to act for me, I request that persons providing care or treatment for me follow any instructions in this document, which should be treated as clear and convincing proof of my wishes.

• My Patient Advocate has authority to act on my behalf to access my medical record and to disclose or consent to the disclosure of my medical record to others. My medical record means information, oral or recorded in any form or medium, about my health care, medical history, diagnosis, prognosis or medical condition.

• My Patient Advocate has the authority to access, disclose or consent to disclosure of my medical record to the same extent that I would have the power to do so, and also after my death to the fullest extent permitted by law.

• Healthcare providers who follow the decisions of my Patient Advocate (or any instructions and wishes expressed in this document if no Patient Advocate is available to act) shall be liable only in the same manner and to the same extent as if I had made the decision on my own behalf.

• This document is signed in the State of Michigan, in accordance with Michigan law.

• I intend that this document be applied to the fullest extent possible if any other state where I may be.

• Photocopies of this document should be considered the same as originals.
My Choices: Instructions for my Patient Advocate

Choice No. 1

I choose to have **ALL MEDICALLY SOUND TREATMENT TO KEEP ME ALIVE**. I would want to be kept alive as long as possible regardless of my condition, quality of life or chances for recovery. I would want every medically sound treatment that my doctors believe could benefit me and that is available within my means.

ADDITIONAL INSTRUCTIONS: ____________________________________________________________________________

______________________________________________________________________________________________

I choose Choice No. 1: _____________________________________________

Initials

OR

Choice No. 2

I choose to have **ALL TREATMENT TO KEEP ME ALIVE UNLESS I AM IN AN IRREVERSIBLE COMA OR PERSISTENT VEGETATIVE STATE WHICH IS EXPECTED TO CONTINUE FOR THE REST OF MY LIFE AS DETERMINED BY MY PHYSICIAN (AND ONE OR MORE APPROPRIATE MEDICAL CONSULTANTS)**. Once it is determined, to the best of the physician’s knowledge, that I will remain in this condition for the rest of my life, I do not want life-sustaining treatment to be provided or continued. I give authority to my Patient Advocate to withhold or withdraw treatment even if these decisions could or would allow my death.

ADDITIONAL INSTRUCTIONS: ____________________________________________________________________________

______________________________________________________________________________________________

I choose Choice No. 2: _____________________________________________

Initials

OR
I choose to give **ALL AUTHORITY TO MY PATIENT ADVOCATE.** **MY PATIENT ADVOCATE IS SPECIFICALLY AUTHORIZED NOT TO PROLONG MY LIFE UNDER ANY OF THE FOLLOWING CONDITIONS:**

A. In the judgement of my physician(s):
   - I am in an irreversible coma or persistent vegetative state; or
   - I have a life-limiting illness and life sustaining procedures would only delay my death; or

B. In the judgment of my Patient Advocate (based on knowledge of my values and beliefs):
   - The burdens of my condition or its treatment outweigh the benefits; or
   - The pain and suffering imposed by treatment outweigh the benefits; or
   - I have physical and/or mental disability, the burdens of which outweigh the benefits in my life.

I give all authority to my Patient Advocate, to withhold or withdraw life sustaining treatment, even if these decisions could or would allow my death. Without limiting my Patient Advocate’s authority to withhold or withdraw treatments as described above, I express my clear intention that I would not want my life prolonged with life sustaining treatment in any of the above situations.

**ADDITIONAL INSTRUCTIONS: ____________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________**

**Choice No. 3**

**Strike out and initial any lines you do not want**

IF YOU SELECTED THIS CHOICE PLEASE GO TO PAGES 19, 20, 21, AND 22 TO COMPLETE THIS LEGAL DOCUMENT

**Choice No. 4**

I choose Choice No. 3: ____________________________________________________________

Initials

This choice requires completion of Choice 4: My Specific Choices. OR Proceed to page 23 and complete rest of this booklet.

I choose to give **INSTRUCTIONS FOR SPECIFIC SITUATIONS.** I have thought about several types of situations and have made choices. These choices are reflected on the attachment called **“My Specific Choices.”** I have signed the pages of the attachment. These choices are to be used by my Patient Advocate as guidelines in making decisions.

If conditions or treatment choices arise that I have not written down or if I have asked that my Patient Advocate decide for me, then I expect my Patient Advocate to make decisions based on:

- The benefits and burdens of each treatment and;
- My Patient Advocate’s knowledge of my personal values and beliefs and/or;
- My best interest

I give authority to my Patient Advocate to withhold or withdraw life-sustaining treatment, even if these decisions could or would allow my death.

I choose Choice No. 4: ____________________________________________________________

Initials
Additional wishes to my choice:

I would want my pain controlled even if pain medications could make me less aware:

☐ Yes    ☐ No    ☐ Uncertain

I give my Patient Advocate(s) the authority to donate my organs and tissue (specific instructions)

________________________________________________________________________
________________________________________________________________________

☐ Yes    ☐ No    ☐ Uncertain

I give my Patient Advocate(s) the authority to donate my whole body for medical education and/or research.

☐ Yes    ☐ No    ☐ Uncertain

Specific Instructions: ______________________________________________________
________________________________________________________________________

I give my Patient Advocate(s) authority to consent to an autopsy.

☐ Yes    ☐ No    ☐ Uncertain

Specific Instructions: ______________________________________________________
________________________________________________________________________

I give my Patient Advocate(s) authority to consent to my participation in clinical trials.

☐ Yes    ☐ No    ☐ Uncertain

Specific Instructions: ______________________________________________________
________________________________________________________________________

My Full Signature

The witness must be present when you sign the document.

See page 20 for witness information.

I am signing this form, making choices and giving instructions of my own free will. I am not being required to sign this form in order to receive care, to qualify for insurance or other benefits, or for any other reason. I am at least 18 years of age and of sound mind. This is a durable power of attorney which shall survive my disability, incapacity or incompetence.

______________________________          ____________________________
Signature                                                                                  Date

______________________________          ____________________________
Printed Name                                                                                ____________________________

______________________________
Phone Number: ( ______ ) ________________________      Address
Witnesses’ Declaration

I declare that the person who signed this document is known to me either personally or by presentation of valid identification (such as driver’s license, passport or state identification card), and that the person signed it in my presence. To the best of my knowledge the person 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).

I declare that, at the time of this signing, I am not the signer’s spouse, parent, child, grandchild, brother or sister, presumptive heir, know beneficiary (devisee), physician or Patient Advocate or Successor Patient Advocate. I am not an employee of the life or health insurance or health benefit provider, health facility or home of the aged which provides services or care for the person who signed the document.

Witness’s Signature

Witness’s Signature

Printed Name

Printed Name

Date

Date

Address

Address

Reaffirmation

There is no expiration date of this document. I understand that:

• It is wise to review it annually and/or if there should be a change in my health status.
• If my wishes change, I may revoke this document in any manner designed to communicate an intent to revoke the document.
• If I am able to do so, I should write the word “REVOKED” on each page, and date and sign each page.
• If I am able to do so, I should tell my Physician, any health care provider that has a copy, my Patient Advocate and any Successor Patient Advocate who has a copy.
• I may replace this document with a new Designation of Patient Advocate form and further instructions about my care, custody and medical treatment.

I reaffirm that as of each date specified below, I still agree with the contents of this document.

Signature ___________________________ Date____________________
Signature ___________________________ Date____________________
Signature ___________________________ Date____________________
Signature ___________________________ Date____________________
Signature ___________________________ Date____________________
Signature ___________________________ Date____________________
Signature ___________________________ Date____________________
Signature ___________________________ Date____________________
Signature ___________________________ Date____________________
Signature ___________________________ Date____________________

If I do not reaffirm the document at any specific time, it remains in full effect.
Acceptance by Patient Advocate
The Patient Advocate and any Successor Patient Advocate must sign this Acceptance before he/she may act as the Patient Advocate

I agree to be Patient Advocate for__________________________________, called the “Patient” in the rest of this Acceptance. I accept the Patient’s choice (designation) of me as the Patient Advocate. I understand and agree to take reasonable steps to follow the wishes and instructions of the Patient in the “My Voice - My Choice”® form, in other written instructions of the Patient, and as the Patient otherwise expresses to me in a clear and convincing manner.

I also understand and agree that:

a. This designation is not effective unless the Patient is unable to participate in medical treatment decisions.

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 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. 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.

e. 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.

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 (persons responsible for acting on behalf of another) when acting for the Patient and shall act in a manner 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 treatment decisions are presumed to be in the Patient’s best interests.

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 Advocate may revoke his or her acceptance of the designation at any time and in any manner sufficient to communicate an intent to revoke.

j. A Patient admitted to a health facility or agency has the right enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Act of 1978, being section 333.20201 of the Michigan Compiled Laws.
If I am unavailable 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:

__________________________________________       Home Phone ____________________________
Signature                                                                             Work Phone ____________________________

__________________________________________       Address
Printed Name                                                                      ______________________________________
Date                                                                                                           
                                                                                                           

SUCCESSOR PATIENT ADVOCATE:

__________________________________________       Home Phone ____________________________
Signature                                                                             Work Phone ____________________________

__________________________________________       Address
Printed Name                                                                      ______________________________________
Date                                                                                                           
                                                                                                           

SUCCESSOR PATIENT ADVOCATE:

__________________________________________       Home Phone ____________________________
Signature                                                                             Work Phone ____________________________

__________________________________________       Address
Printed Name                                                                      ______________________________________
Date                                                                                                           
                                                                                                           

SUCCESSOR PATIENT ADVOCATE:
Choice 4: My Specific Choices

This is a legal document which is part of my Patient Advocate Designation for Health Care Decisions (Durable Power of Attorney for Healthcare) called “My Voice - My Choice”®.

This attachment is part of treatment Choice No. 4: I have thought about several types of situations and have made my choices.

INSTRUCTIONS

This booklet describes seven (7) situations.

1. For each situation, mark the box that describes how you would feel if you were in the same or a similar type of situation.

2. For each treatment listed, mark the box that would be your choice.

3. Initial each page.

4. If you choose not to complete a page, you may check the box that allows the Patient Advocate to choose (far right column). If you do not complete a page or a particular questions, Choice 4 allows your Patient Advocate to make the choice, whether or not your check that box.

5. After completing this section, go back to the “My Voice - My Choice”® booklet and complete pages 19 through 22.

Oakwood Healthcare System, Inc. acknowledges the pioneering work of Linda L. Emanuel and Ezekiel J. Emanuel, as published in the Journal of the American Medical Association 261:3288-3293, June 3, 1989, and the prior adaptations of their work in “Your Life, Your Choices” by Robert Pearlman of the University of Washington. There is no connection between these authors and Oakwood Healthcare System, Inc.
Situation 1: My Quality of Life Today

If I had a serious illness or injury and the doctors believed that with treatment I could recover to about the same quality of life as I have now, then I would want the treatments marked below. If I choose not to receive a treatment, I understand that it could or would allow my death.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>I would want this if my doctors believe it would benefit me.</th>
<th>I would <strong>not</strong> want this even if it might benefit me.</th>
<th>I don’t know. My advocate should decide.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiopulmonary Resuscitation (CPR)</strong> if my heart or breathing stopped (includes chest compressions, use of breathing tube, defibrillation and emergency medications as part of the procedure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Electrical therapies</strong> such as defibrillation, cardioversion or pacemaker to correct my heart beat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency IV medications</strong> for my heart and/or blood pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mechanical Ventilation:</strong> for as long as needed until I get better</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Feeding Tube:</strong> for as long as needed until I get better</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dialysis:</strong> for as long as needed until I get better</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transfusion</strong> of blood or blood products</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Feel free to add specific instructions or time frames to better express your views.

Initials:__________________
Situation 2: Physical Disability

If I had a severe, incurable physical disability, this is how I would feel:

- [ ] Life would be acceptable
- [ ] Life would be hard but acceptable
- [ ] Life would be just barely worth living
- [ ] Life would not be worth living

If, in addition to the above condition, I also had a life-threatening illness or injury that could cause my death, I would want the treatments marked below. If I choose not to receive a treatment, I understand that it could or would allow my death.

<table>
<thead>
<tr>
<th>Treatment Description</th>
<th>Would Want this if my doctors believe it would benefit me</th>
<th>Would not want this even if it might benefit me</th>
<th>My advocate should decide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPR</strong> if my heart or breathing stopped (includes chest compressions, use of breathing tube, defibrillation and emergency medications as part of the procedure)</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Electrical therapies</strong> such as defibrillation, cardioversion or pacemaker to correct heart rate</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical placement of a <strong>permanent electrical device</strong> (such as a pacemaker)</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency IV medications</strong> for the heart and/or blood pressure</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mechanical Ventilation:</strong> until I could breathe on my own</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for a lifetime if I could not breathe</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Feeding Tube:</strong> until I could eat on my own</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for a lifetime if I could not eat</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dialysis:</strong> until my kidneys worked again</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for a lifetime if my kidneys did not work</td>
<td>-funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transfusion</strong> of blood or blood products</td>
<td>-funded</td>
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<td></td>
</tr>
</tbody>
</table>

Feel free to add specific instructions or time frames to better express your views.

Initials: ____________________
Situation 3: Incurable Illness

If I had an illness which has no cure and I am not expected to live more than about 1 year, this is how I would feel:

- [ ] Life would be acceptable
- [ ] Life would be hard but acceptable
- [ ] Life would be just barely worth living
- [ ] Life would not be worth living

If, in addition to the above condition, I had another life-threatening illness or injury that could cause my death, *I would want the treatments marked below*. If I choose the treatments I may live for awhile, but I would still have my incurable illness. If I choose not to receive a treatment, I understand that it could or would allow my death.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>I would want this if my doctors believe it would benefit me.</th>
<th>I would <strong>not</strong> want this even if it might benefit me.</th>
<th>I don’t know. My advocate should decide.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPR</strong> if my heart or breathing stopped (includes chest compressions, use of breathing tube, defibrillation and emergency medications as part of the procedure)</td>
<td><img src="Blank" alt="Blank" /></td>
<td><img src="Blank" alt="Blank" /></td>
<td><img src="Blank" alt="Blank" /></td>
</tr>
<tr>
<td><strong>Electrical therapies</strong> such as defibrillation, cardioversion or pacemaker to correct heart beat</td>
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<td><img src="Blank" alt="Blank" /></td>
<td><img src="Blank" alt="Blank" /></td>
</tr>
<tr>
<td>Surgical placement of a <strong>permanent electrical device</strong> (such as a pacemaker)</td>
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<tr>
<td><strong>Emergency IV medications</strong> for the heart and/or blood pressure</td>
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<td>for as long as needed until I get better</td>
<td><img src="Blank" alt="Blank" /></td>
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<td>for a lifetime if I could not breathe</td>
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Feel free to add specific instructions or time frames to better express your views.

Initials: ______________________
**Situation 4: Irreversible Coma or Persistent Vegetative State**

If I were in an irreversible coma or persistent vegetative state, in which I am not conscious and others must provide for all my needs, this is how I would feel:

<table>
<thead>
<tr>
<th></th>
<th>Life would be acceptable</th>
<th>Life would be hard but acceptable</th>
<th>Life would be just barely worth living</th>
<th>Life would not be worth living</th>
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</table>

If, in addition to the above condition, I were to have a life-threatening illness or injury that could cause my death, **I would want the treatments marked below** even though I would still be unconscious and not expected to wake up. If I choose not to receive a treatment, I understand that it could or would allow my death.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>I would want this if my doctors believe it would benefit me</th>
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<tr>
<td>for as long as needed until I get better</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for a lifetime if I could not get better</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dialysis:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for as long as needed until I get better</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>for a lifetime if I could not get better</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transfusion</strong> of blood or blood products</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Feel free to add specific instructions or time frames to better express your views.

Initials: ____________________
Situation 5: Chronic Mental Confusion:

If I had severe, irreversible mental confusion (example: Alzheimer’s Disease) that is expected to get worse and I would not recover from it, this is how I would feel:

- Life would be acceptable
- Life would be hard but acceptable
- Life would be just barely worth living
- Life would not be worth living

In addition to the above condition, if I had a life-threatening illness or injury that could cause my death, I would want the treatments marked below. If I choose the treatments I may live, but I would still be confused. If I choose not to receive a treatment, I understand that it could or would allow my death.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>I would want this if my doctors believe it would benefit me</th>
<th>I would not want this even if it might benefit me</th>
<th>I don’t know. My advocate should decide</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrical therapies</td>
<td>such as defibrillation, cardioversion or pacemaker to correct heart beat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical placement of a permanent electrical device (such as a pacemaker)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency IV medications for the heart and/or blood pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mechanical Ventilation: until I could breathe on my own</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for a lifetime if I could not breathe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding Tube: until I could eat on my own</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for a lifetime if I could not eat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis: until my kidneys worked again</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for a lifetime if my kidneys did not work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfusion of blood or blood products</td>
<td></td>
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</tbody>
</table>

Feel free to add specific instructions or time frames to better express your views.

Initials:___________________
Situation 6: Mental Disability

If I had a severe, incurable mental disability, this is how I would feel:

- [ ] Life would be acceptable
- [ ] Life would be hard but acceptable
- [ ] Life would be just barely worth living
- [ ] Life would not be worth living

If, in addition to the above condition, I also had a life-threatening illness or injury that could cause my death, I would want the treatments marked below. If I choose not to receive a treatment, I understand that it could or would allow my death.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>I would want this if my doctors believe it would benefit me.</th>
<th>I would not want this even if it might benefit me.</th>
<th>I don’t know. My advocate should decide.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR if my heart or breathing stopped (includes chest compressions, use of breathing tube, defibrillation and emergency medications as part of the procedure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrical therapies such as defibrillation, cardioversion or pacemaker to correct heart beat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical placement of a permanent electrical device (such as a pacemaker)</td>
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Feel free to add specific instructions or time frames to better express your views.

Initials: ____________________
Situation 7: Current Diagnosed Mental Illness* (if applicable)

I have a mental illness known as: _____________________________________________________

I understand that it is very important for me to have consistent treatment, and that there may be times in the course of my illness when I will not follow the medical treatments necessary for my mental illness.

I understand that it is in my best interest to continue my treatment. This includes taking my medicine as directed, and not discontinuing my medications or any other aspect of my treatment without agreement of my physician or other mental health practitioner.

I understand that it may be necessary for me to be hospitalized. I also understand that even though I may want to leave the hospital, it is in my best interest to remain hospitalized and to complete a treatment regimen until appropriately discharged by my physician or other mental health practitioner.

Because I understand how important it is for me to receive all treatment necessary to control my mental illness, I hereby (strike through, initial and date any section that you do not agree with):

• designate my patient advocate to make all medical treatment decisions for me that are related to or necessary for promotion of my mental health. This will occur whenever a physician and mental health practitioner both certify in writing that I am unable to give informed consent to mental health treatment. I prefer that my own physician and mental health practitioner make this certification, but if they are unavailable or unwilling to examine me, then I authorize any other physician or mental health professional to examine me for this purpose.

As a part of this authority, I hereby designate my patient advocate, when acting on the advice of my physicians and other mental health practitioners:

• to make decisions relating to treatment that I specifically state at the time I do not want. I hereby intend to state in a clear and convincing way that I give to my patient advocate all authority to accept or reject any such treatment on my behalf regardless of the views I may express at the time.

• to act as my representative in making any application for formal voluntary hospitalization. I understand that there may be times when I am hospitalized and will want to leave. I hereby give to my patient advocate all authority to determine when my hospitalization shall be terminated, notwithstanding any rights I would otherwise have to terminate a voluntary hospitalization for a period of not less than thirty (30) consecutive days.

• to act as my representative and to express my preferences in the formation of a treatment plan for me in any case in which a court is fashioning an order for assisted outpatient treatment for my mental illness.

*Some examples: Schizophrenia, Bipolar Disorders, Obsessive Compulsive Disorders or other diagnosed mental illnesses.
• to make decisions for any treatment as I have directed in situations 1 through 6 above, during any period when I am unable to make decisions as a result of my mental illness as certified by a physician and mental health practitioner for this purpose.

I hereby waive any right that I might have under ordinary circumstances to revoke my patient advocate designation for any period of up to thirty (30) consecutive days and for subsequent periods of up to thirty (30) consecutive days if I am again determined to be unable to give informed consent to treatment for my mental illness.

Other specific instructions: ______________________________________________________
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____________________________________________________________________________
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Initials _______________________

See “My Voice - My Choice”® pages 19 and 20 for full signature and witnesses.

Please feel free to add specific instructions or time frames to better express your views.
____________________________________________________________________________
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Initials____________________