Designation of Medical/Patient Advocate Form

Patient Name:

Patient Date of Birth:

To my Family, Doctors, and All Concerned with My Care:

These instructions express my wishes about my healthcare. I want my family, doctors, and everyone else concerned with my care to act in accordance with them.

Appointment of Medical/Patient Advocate

I appoint the following person as my Medical/Patient Advocate.

Medical/Patient Advocate Name:	
Medical/Patient Advocate Address:	
Medical/Patient Advocate Telephone	
Home:	
Work:	
Mobile:	

Appointment of Successor Medical/Patient Advocate(s)

I appoint the following person(s), in the order listed, as my successor Medical/Patient Advocate if my first Medical/Patient Advocate cannot accept my appointment, is incapacitated, resigns, is removed, or I am divorced or separated from him/her after the date signed on this form.

My successor Medical/Patient Advocate will have the same powers and rights as my first Medical/Patient Advocate.

Successor Medical/Patient Advocate #1 Name:	
Successor Medical/Patient Advocate #1 Address:	
Successor Medical/Patient Advocate #1 Telephone	
Home:	
Work:	
Mobile:	
Successor Medical/Patient Advocate #2 Name:	
Successor Medical/Patient Advocate #2 Address:	
Successor Medical/Patient Advocate #2 Telephone	
Home:	
Work:	
Mobile:	

My Medical/Patient Advocate or successor Medical/Patient Advocate may delegate his or her powers to the next successor Medical/Patient Advocate if he or she is unable or unwilling to act on my behalf

My Medical/Patient Advocate or successor Medical/Patient Advocate may act on my behalf ***IF I AM ABLE*** TO PARTICIPATE IN MAKING DECISIONS REGARDING MY MEDICAL TREATMENT ***AND IF I AM UNABLE*** TO PARTICIPATE IN MAKING DECISIONS REGARDING MY MEDICAL TREATMENT.

(This section gives instructions for your care. Cross out and initial any instructions you do not want.)

Under instruction 1.b., your Medical/Patient Advocate has the right to make arrangements for your care but is not personally responsible for the cost of your care.

Instructions For Care

1. General Instructions

My Medical/Patient Advocate shall have authority to make all decisions and to take all actions regarding my care, transfer of care, and custody, including, but not limited to the following:

a. Have access to, obtain copies of and authorize release of my medical, mental health, and other personal information.

b. Hire and discharge physicians, nurses, therapists, any other healthcare providers, mental health professionals, and other providers and arrange to pay them reasonable compensation.

c. Consent to, refuse, or withdraw on my behalf any medical or mental health care; diagnostic, surgical or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments. I understand life-sustaining treatment includes, but is not limited to, breathing with the use of a machine and receiving food, water, and other liquids through tubes. I also understand these decisions could or would allow me to die. I have listed below and on the following pages any specific instructions I have related to life-sustaining treatments.

2. Specific Instructions

My Medical/Patient Advocate is to be guided in making medical and mental health decisions for me by what I told him or her about my personal preferences regarding my care. Some of my preferences are recorded on the following pages.

Pages below list choices concerning your general wishes regarding life-sustaining treatment, as well as an option to list types of care that you specifically do or do not want.

Pages below contain a list of many future healthcare and end-of-life topics that you may choose to address in this document.

a. Specific Instructions Regarding Medical Examinations

My religious beliefs prohibit a medical examination to determine whether I am unable to participate in making medical treatment decisions. I desire this determination to be made in the following manner:

b. Specific Instructions Regarding Life-Sustaining Treatment

I understand that I do not have to choose one of the instructions regarding life-sustaining treatment listed below. If I choose one, I will sign below my choice.

Regardless of whether I sign one of the choices listed below, I direct that reasonable measures be taken to keep me comfortable and relieve pain.

Choice 1: Regardless of my condition, I do not want life-sustaining treatment initiated.

I understand this decision could or would allow me to die.

If this statement reflects your desires, sign here: ___________________________________

Choice 2: If I have an end-stage illness or irreversible condition, I do not want life-sustaining treatment initiated.

I understand this decision could or would allow me to die.

If this statement reflects your desires, sign here: ___________________________________

Choice 3: If I have an end-stage illness or irreversible condition, I want my life to be prolonged by life-sustaining treatment until it is determined by my physician that medical intervention is futile. At that time, I want all life-sustaining treatment discontinued.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here: ___________________________________

Choice 4: I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition, chances I have for recovery, or cost of my care, and I direct life-sustaining treatment be provided in order to prolong my life.

If this statement reflects your desires, sign here: ___________________________________

c. Additional Specific Instructions Regarding Care I DO or DO NOT Want:

Optional Provisions

The following designation, authorizations, and waiver are optional. If you choose to affirm any of the options, please check the corresponding box and sign where indicated.

____ Specific Instructions Regarding Organ and Tissue Donation: My Medical/Patient Advocate has authority, upon or immediately before my death, to make an anatomical gift of all or a part of my body for therapy or transplantation needed by another individual; for medical or dental education, research or advancement of medical or dental science; or for any other purpose permitted by law. This authority granted to my Medical/Patient Advocate shall remain exercisable following my death.

____ I designate a particular physician and/or mental health practitioner to examine me and make the determination as to my ability to participate in medical treatment decisions.

Name of Physician(s) and/or Mental Health Practitioner(s):

Xxxx

This document is to be treated as a Durable Power of Attorney for Healthcare and shall survive my disability or incapacity. If I am unable to participate in making decisions for my care and there is no Medical/Patient Advocate or successor Medical/Patient Advocate able to act for me, I request that instructions I have given in this document be followed and that this document be treated as conclusive evidence of my wishes. It is also my intent that anyone participating in my medical treatment shall not be liable for following directions of my Medical/Patient Advocate consistent with my instructions.

The following are my personal preferences that may or may not be appropriate, or possible, given unknown circumstances I may face in the future. I ask that these preferences be considered and honored when possible, reasonable, and medically and financially appropriate. I authorize my Medical/Patient Advocate to make final decisions in these matters when dealing with future circumstances in which these preferences become relevant.

You do not have to write anything on this page, but if you have preferences regarding any of these topics, please use the space below to express them.

Preferences Regarding Palliative Care (Symptom Management):

Preferences Regarding Long Term Care and Housing:

Preferences Regarding Artificial Nutrition or Tube Feeding:

Preferences Regarding Hospice:

Regarding My Views on Life:

Regarding Special Preferences:

Regarding Final Thoughts and Hopes:

Other Things I Want My Medical/Patient Advocate to Know:

Sign and date below in the presence of at least two witnesses who meet the following requirements:

The individuals ARE:

- At least 18 years of age
- Of sound mind

The individuals ARE NOT:

- Your husband or wife, parent, child, grandchild, grandparent, brother or sister
- Your presumptive heir
- A known beneficiary of your will at the time of witnessing
- Your physician
- A person named as your Medical/Patient Advocate
- An employee of your life or health insurance provider
- An employee of a health facility that is treating you
- An employee of a home for the aged where you reside

This document is signed in the State of Tennessee. I intend that it be applied to the fullest extent possible wherever I may be. Photocopies of this document can be relied upon as though they were originals.

My signature represents my intent to expressly revoke any and all previous patient-advocate designations. Instructions for care in this document represent my current treatment decisions. Any document or statement inconsistent with this document is expressly revoked.

I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn. I am at least eighteen years old and of sound mind.

Signature

Sign Name ____________________________________ Date ______________________________

Printed Name ____

Address ____

Witness Statement and Signatures

If the witness does not personally know the person who is signing this Designation, the witness should ask for identification, such as a driver's license.

I declare that the person who signed this Designation of Medical/Patient Advocate signed it in my presence and is known to me. I also declare that the person who signed appears to be of sound mind and under no duress, fraud or undue influence and is not my husband or wife, parent, child, grandchild, grandparent, brother or sister. I declare that I am not the presumptive heir of the person who signed above, the known beneficiary of his/her will at the time of witnessing, his/her physician or a person named as Medical/Patient Advocate. I also declare that I am not an employee of a life or health insurance provider for the person who signed, an employee of a health facility that is treating him/her, or an employee of a home for the aged where he/she resides. I am at least eighteen years old and of sound mind.

Witnesses Signatures

Sign Name ____________________________________ Date ______________________________

Printed Name ____

Address ____

Sign Name ____________________________________ Date ______________________________

Printed Name ____

Address ____

You should discuss this document with the person(s) you want to have as your Medical/Patient Advocate(s) and have him/her sign the Acceptance of Medical/Patient Advocate on the following page:

Medical/Patient Advocate Designation Acceptance

I, ______________________, accept the designation of Medical/Patient Advocate for ________________________, and I agree to perform the duties given to me as Medical/Patient Advocate, subject to terms, conditions and restrictions specified below.

(a) Effective
This designation is effective when executed by the patient and myself as designated Medical/Patient Advocate. It is also effective if the patient is unable to participate in medical treatment decisions.

(b) Limitations
I will not exercise sole powers concerning the patient's medical treatment if the patient is able to participate in medical decisions.

(c) Withholding Treatment
I will not make a decision to withhold or withdraw treatment that would allow the patient to die unless the patient clearly expressed I am authorized to make such a decision, and that he or she understands such a decision could cause his or her death.

(d) Compensation
I will not receive compensation for performance of my responsibilities, but I may be reimbursed for expenses.

(e) Fiduciary Standards
I will act consistent with the patient's best interests. The desires of the patient expressed while able to participate in treatment decisions are presumed to be in the patient's best interests.

(f) Revocation of Designation
The patient may waive his or her right to revoke designation immediately, at any time, by expressing his or her intent to revoke.

(g) Revocation of Acceptance
I may revoke this acceptance at any time by expressing my intent to revoke.

(h) Patient Rights
A patient admitted to a health facility has the rights enumerated in the Tennessee Constitution, as amended.

(i) Anatomical Gifts
My authority to make a donation of bodily organs may be exercised after the patient's death.

This is the continuation of the Medical/Patient Advocate Designation Acceptance portion of your document. You must have your Medical/Patient Advocate(s) sign below in order for them to be able to act as your Medical/Patient Advocate.

If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the persons the patient designated as successor Medical/Patient Advocate in the order designated. The successor Medical/Patient Advocate is authorized to act until I become available to act.

Medical/Patient Advocate

Printed Name:

Medical/Patient Advocate Signature:

Date:

Successor Medical/Patient Advocate #1

Printed Name:

Successor Medical/Patient Advocate #1 Signature:

Date:

Successor Medical/Patient Advocate #2

Printed Name:

Successor Medical/Patient Advocate #2 Signature:

Date:

Keep the signed original with your personal papers at home. Please give a copy to your Medical/Patient Advocate(s), your physician, and hospital where you are likely to receive treatment. If you decide to update this document, please be sure to revoke all copies you distributed. You may do this by writing "revoked" across the document, or by disposing of the document. Once you have revoked a version of this document and created a new one, make sure all parties who need a copy are given copies of your revised document. (Complete the following so it will be easy to track your documents should you ever revise or replace your current document.) This document must be copied in its entirety, even if sections are left blank.

I have given copies of my Designation of Medical/Patient Advocate Form to the following:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Other Things I Want My Medical/Patient Advocate to Know

Please use this space for any special preferences you would like your Medical/Patient Advocate to know that you were unable to fit on previous pages.

Reaffirming Your Designation of Medical/Patient Advocate Form

You should review this document from time to time to be certain that it still conveys your beliefs and desires for future healthcare. It's helpful to remember to reaffirm or change your Designation of Medical/Patient Advocate Form when experiencing any of "The Five D's." The Five D's are:

Divorce (A divorce could alter your choice of Medical/Patient Advocate even if your Advocate is someone other than your former spouse.)

Death (The death of your Medical/Patient Advocate must be addressed to ensure that there is someone to speak on your behalf if you become unable to speak for yourself. Also, experiencing a death of someone close to you, even if they were not your Advocate, may impact the decisions you've declared in this document.)

Diagnosis (If you or your Medical/Patient Advocate have received a new diagnosis, it may impact the desires and instructions you have listed in this document. It may also impair you Advocate's ability to speak on your behalf in the future.)

Decline (If you or your Medical/Patient Advocate have experienced a decline in health, it is a good idea to re-assess your wishes and roles moving forward. It is important that your Advocate have the ability to communicate your wishes if you become unable to speak for yourself.)

Decade (If you haven't re-read this document in 10 years, it is wise to review it and make sure that it still reflects your intentions.)

When you review this document, if it still expresses your intent, sign and date under the Reaffirmed section below to show that you still agree with its contents. If your wishes have changed, destroy or revoke this document as described, complete a new one, and give a copy to everyone who needs to have the new version.

REAFFIRMED

Date___________________________________ Signature ________________________________

Date___________________________________ Signature ________________________________

Date___________________________________ Signature ________________________________