Introduction

This document provides a way for you to create a Durable Power of Attorney for Healthcare (Patient Advocate Designation) and other documentation that will meet the basic requirements for this state. This Advance Directive (AD) allows you to appoint a person (and alternates) who shall take reasonable steps to follow the desires and instructions indicated within this document, or in other written or spoken treatment preferences.

The person you appoint is called your Patient Advocate. This document gives your consent to allow your Patient Advocate to make decisions only when two physicians, or a physician and a licensed psychologist, have determined you are unable to make your own decisions. Every resident age 18 and over should appoint a Patient Advocate, as accidents can happen to anyone, at any time.

Note: This AD does not give your Patient Advocate permission to make your financial or other business decisions.

Before completing this document, take time to read it carefully. It also is very important that you discuss your views, your values, and this document with your Patient Advocate(s).

If you do not closely involve your Patient Advocate(s), and you do not make a clear plan together, your views and values may not be fully followed because they will not be understood.

تقدم تلك الوثيقة طريقة لإنشاء توكيل دائم للرعاية الصحية (تعيين مُشاوِّر المريض) وغير ذلك من الوثائق التي تستلزم المتطلبات الأساسية لهذه الولاية. يُتيح لك التوجيه المُ힙َّ (Advance Directive, AD) إنشاء توكيل دائم (دائم التوكل) لإتخاذ القرارات العقلية لاكتساب الرغبات والتوقعات المضللة التي يعانيها المريض، أو في غيرها من تفضيلات الإصابة المحددة أو المنطوقة. يُسمح ذلك الشخص الذي تعيينه مناصر المرض، وفقًا لỌاية ميشيغان، أن يُقرر على اتخاذ قراران بنفسه.

وعلى كل مُعطي يبلغ من العمر 18 عامًا فأكبر أن يُعِين مناصر مريض، تحتسبًا لما قد يصيب الجميع من حوادث، في أي وقت.

Note: This AD does not give your Patient Advocate permission to make your financial or other business decisions.

Before completing this document, take time to read it carefully. It also is very important that you discuss your views, your values, and this document with your Patient Advocate(s).

If you do not closely involve your Patient Advocate(s), and you do not make a clear plan together, your views and values may not be fully followed because they will not be understood.

تتأثر في قراءة هذه الوثيقة بعناية، قبل توقيعها. ومن المُنصح جدًا كذلك أن تُناقش وجهات نظرك وقيمتكم. إن تُشترط عن كثب مُشاوِّر المريض (المرضي) المريض الخاص بك. ولم تضخ خطة واضحة معلقة. فقد لا تُناقش وجهات نظرك وقيمتكم كلًا لأنها ستكون غير مفهومة.
This document was developed to meet the legal requirements of Michigan. It is not designed to replace the counsel of your attorney.

وُُوُُضُعت هذه الوثيقة لتلبِّي المتطلبات القانونية لميشيغان. وهي غير مُضمنة لتجل محل استشارة محامي.

This is an Advance Directive for (print legibly):

لا يوجد نص يمكن قراءته بشكل طبيعي.

Name/اسم: __________________________ Date of Birth/تاريخ الميلاد: __________________________ Last 4 digits of SSN/أرقام أربعة أخر 4 أرقام من رقم الضمان الاجتماعي: __________________________

(Social Security number, SSI) (الاجتماعي رقم): __________________________

Telephone: Primary (Cell) __________________________ Secondary (Cell) __________________________

الهاتف: الأساسي (الخلوي) __________________________ الثانوي (الخلوي) __________________________

Address/العنوان: ________________________________________________________________

City/State/Zip/المدينة/الولاية/الرمز البريدي: __________________________

Where I would like to receive hospital care/أين أود تلقي الرعاية في المستشفى: __________________________

(whenever possible): __________________________
When either two physicians or a physician and licensed psychologist determine I am unable to make health care decisions, this document names the person(s) I have chosen to be my Patient Advocate(s). They shall take reasonable steps to carry out my treatment preferences. I understand that it is important to regularly talk with my Patient Advocate(s) about my health and treatment preferences. I hereby give my Patient Advocate(s) permission to share a copy of this document with other doctors, hospitals and health care providers that provide my medical care.

Based on my expressed religious beliefs, I would prohibit having an examination for determination to participate in medical decision-making by a doctor, licensed psychologist or another medical professional. Instead, I request the determination for incapacity be made in the following manner:

If I leave this section blank, I am leaving the evaluation decision to my Patient Advocate(s)

(Originally: If your wishes change, you may revoke your Patient Advocate Designation at any time and in any manner sufficient to communicate an intent to revoke. It is recommended that you complete a new Advance Directive and give it to everyone who has a previous copy).

(Translation: If you change your mind, you may withdraw your designation at any time and in any manner that clearly communicates your intention to do so. It is recommended that you complete a new Advance Directive and distribute it to everyone who has a previous copy.)
The person I choose as my Patient Advocate is

الشخص الذي أختاره ليكون مناصري المريض الخاص بي هو

Name/اسم: __________________________________ Relationship/الصلة: ____________________________

Telephone: Primary (Cell ) _________________________ Secondary (Cell ) ________________________________

_____________________________________________________________ (الهاتف: الأساسي (الخليوي)

الثانيو (الخليوي)

Address:/ العنوان

City/State/Zip Code/: ________________________________________________________________

First Alternate (Successor) Patient Advocate (strongly advised)

البديل الأول لمناصري المريض (مناصري المريض اللاحق) (يُنصح بذلك بشدة)

If Patient Advocate above is not capable or willing to make these choices for me, then I designate the following person to serve as my Patient Advocate.

إن كان مناصري المريض المذكور أعلاه غير قادر على اتخاذ تلك القرارات تابعةٌ ﺛalties ﻋن ﻣر ت ل، فاذا أعين

الشخص التالي ليلعب دور مناصر المريض الخاص بي.

Name/الاسم: __________________________________ Relationship/الصلة: ____________________________

Telephone: Primary (Cell ) _________________________ Secondary (Cell ) ________________________________

_____________________________________________________________ (الهاتف: الأساسي (الخليوي)

الثانيو (الخليوي)

Address:/ العنوان

City/State/Zip Code/: ________________________________________________________________

Second Alternate (Successor) Patient Advocate (strongly advised)

البديل الثاني لمناصري المريض (مناصري المريض اللاحق) (يُنصح بذلك بشدة)

If the Patient Advocates named above are not capable or willing to make these choices for me, then I designate the following person to serve as my Patient Advocate.

إن كان مناصري المريض المذكورون أعلاه غير قادرين على اتخاذ تلك القرارات تابعةٌ ﺛalties ﻋن ﻣر ت ل، فاذا أعين

الشخص التالي ليلعب دور مناصر المريض الخاص بي.

Name/الاسم: __________________________________ Relationship/الصلة: ____________________________

Telephone: Primary (Cell ) _________________________ Secondary (Cell ) ________________________________

_____________________________________________________________ (الهاتف: الأساسي (الخليوي)

الثانيو (الخليوي)

Address:/ العنوان

City/State/Zip Code/: ________________________________________________________________
Advance Directive
التوجيه المسبق
Signature Page
 صفحة التوقيع

I give my Patient Advocate express permission to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death.

I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life-sustaining treatment, such as, but not limited to: ventilator (breathing machine), cardiopulmonary resuscitation (CPR), nutritional tube feedings, intravenous (IV) hydration, kidney dialysis, blood pressure or antibiotic medications — and hereby give my Patient Advocate(s) express permission to help me achieve my goals of care. This may include beginning, not starting, or stopping treatment(s). I understand that such decisions could or would allow my death.

Medications and treatment intended to provide comfort or pain relief shall not be withheld or withdrawn.

_____ I agree with this statement _____ I do not agree with this statement

أعطي لمناصري المريض الخاص بي الإذن للقرارات بوقف أو إلغاء علاج مما يمكن أن يسمح بوفاني. مثل تلك القرارات يمكن أن تؤدي إلى وفتي.

This Advance Directive includes the following sections: Spiritual/Religious Preferences; End of Life Care; Anatomical Gift(s)

Donation; Autopsy Preference; Mental Health Treatment; & Treatment Preferences (Goals of Care).

أصدرت توجيهي المسبق (المناصري) للاختيار الخاص بي فيما يتعلق برغبتي وأهدافي بشأن استخدام العلاج (الأقسام للحياة، ومن ذلك مثلاً: جهاز التنفس الصناعي أو الأنسجة أو الدواء، والوقت الإضافي، ومرونة ضبط الدم أو المضادات الحيوية، واعدة بوجوب ذلك مناصري المريض الخاص سيغلي المحلي على تحقيق أهداف من الرعاية. وقد يتضمن ذلك بدائل العلاج (العلاجات)، أو إنها، أو إيقافها. أدرك أن مثل هذه القرارات يمكن أن يسمح بوفاني أو يُحذّر أن تسمح بوفاني.

الأدوية والعلاجات التي يقصد بها توفير الراحة أو تخفيف الألم لا ينبغي إيقافها أو التراجع عنها.

أوافق على هذه العبارة لا أوافق على هذه العبارة

يتضمن هذا التوجيه المسبق الأقسام التالية: التفضيلات الروحانية/الدينية، ورعاية نهاية الحياة، والهيئة (الدكتور) التشريحي - التبرع بالأعضاء/الأنسجة/الأنسج، والتفصيل بشأن تشريح الجثة، ورعاية الصحة العقلية، وتفصيلات العلاج (أهداف الرعاية).

Signature of the Individual in the Presence of the Following Witnesses
توقيع الفرد في وجد الشهود التالي ذكرهم

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind.

أقدم هذه التعليمات بكمال إرادتي الحرة، ولم يطلب مني تقديمها لتلقي الرعاية أو لإيقاف الرعاية أو التراجع عنها. يبلغ عمري ثمانية عشر (18) عاماً وأنا في كامل قوامي العقلية.

Signature/التوقيع: ____________________________ Date/التاريخ: ____________________________

Address/العنوان: ____________________________ City/State/Zip: ____________________________

المدينة/الولاية/الرمز البريدي: ____________________________
Signatures of Witnesses

I know this person to be the individual identified as the “Individual” signing this form. I believe him or her to be of sound mind and at least eighteen (18) years of age. I personally saw him or her sign this form, and I believe that he or she did so voluntarily and without duress, fraud, or undue influence. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not the Patient Advocate or alternate Patient Advocate appointed by the person signing this document.
- Not the patient's spouse, parent, child, grandchild, sibling or presumptive heir.
- Not listed to be a beneficiary of, or entitled to, any gift from the patient's estate.
- Not directly financially responsible for the patient's health care.
- Not a health care provider directly serving the patient at this time.
- Not an employee of a health care or insurance provider directly serving the patient at this time.

Signature/توقيع: ___________________________ Date/التاريخ: ________________

Print Name/الاسم بالحروف واضحة: ___________________________

Address/العنوان: _______________________________

City/State/Zip Code/المدينة/الولاية/الرقم البريدي: ___________________________________

Witness Number 2: I meet the witness requirements stated above

Signature/توقيع: ___________________________ Date/التاريخ: ________________

Print Name/الاسم بالحروف واضحة: ___________________________

Address/العنوان: _______________________________

City/State/Zip Code/المدينة/الولاية/الرقم البريدي: ___________________________________
Accepting the Role of Patient Advocate

The person named above has asked you to serve as his or her Patient Advocate (or as an alternate Patient Advocate). Before agreeing to accept the Patient Advocate responsibility and signing this form, please:

1. Carefully read the Introduction (1A), “The Advance Care Planning Process” (separate document), and this completed Patient Advocate Designation Form, (including any optional Preferences) listed on pages 6A-9A. Also, take note of any Treatment Preferences ((Goals of Care), pages 1B-2B) and/or Statement of Treatment Preferences that may be attached. These documents will provide important information that you will use in discussing the person’s preferences and in potentially acting as this person’s Patient Advocate.

2. Discuss, in detail, the person’s values and wishes, so that you can gain the knowledge you need to allow you to make the medical treatment decisions he or she would make, if able.

3. If you are at least 18 years of age and are willing to accept the role of Patient Advocate, read, sign and date the following statement.

I accept the person’s selection of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the person as indicated within this “Advance Directive: My Patient Advocate” document or in other written or spoken instructions from the person. I also understand and agree that, according to Michigan law:

- A23.2. قرارات العلاج الطبي على الطرف الذي كان سيتعالج، أو من يختار ذلك.
- إن كان عمرك 18 عامًا على الأقل وكانت راغبًا في قبول دور مناصر المريض، فعليك قراءة البيان التالي وتوقعه.

A23.3.1. أقول اختيار هذا الشخص لي كمناصر للمريض، أدرك وأوافق أن علىتك إتخاذ خطوات معقولة لقاعدة مغbaby وتعليمات هذا الشخص على نحو المثير إليه ضمن وثيقة “التجهي المتعلق: مناصر المريض الخاص بي” أو في غير ذلك من التعليمات المكتوبة أو المتناولة الصادرة عن ذلك الشخص. أدرك وأوافق كذلك أنه، حسب قانون ميشيغان، فإن:

a. This appointment shall not become effective unless the patient is unable to participate in medical or mental health treatment decisions, as applicable.

b. I will not exercise powers concerning the patient’s care, custody, medical or mental health 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. I cannot make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant, if that would result in the patient’s death, even if these were the patient’s wishes.
d. I can make a decision to withhold or withdraw treatment which would allow the patient to die only if he or she has expressed clearly that I am permitted to make such a decision, and the patient understands that such a decision could or would allow his or her death.

e. I may not receive payment for serving as Patient Advocate, but I can be reimbursed for actual and necessary expenses which I incur in fulfilling my responsibilities.

f. I am required to act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act 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 or mental health treatment decisions are presumed to be in the patient’s best interests.

The patient may revoke his or her appointment of me as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.

g. The patient may waive the right to revoke a designation as to the power to exercise mental health treatment decisions, and if such waiver is made, the patient’s ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

h. I may revoke my acceptance of my role as Patient Advocate 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 Michigan Public Health Code, (Exercise of Rights by Patient’s Representative 1978 PA 368, MCL 333.20201).
Accepting the Role of Patient Advocate (continued)

قبول دور مناصر المريض (يَرْتَبِع)

Patient Advocate Signature and Contact Information

توقيع مناصر المريض ومعلومات الاتصال بها

I, ____________________________________________________, am assigning the Patient Advocate(s) listed below:

Print your name above and your Date of Birth here: _____________________

My Patient Advocate(s) will serve in the order listed below:

I, _______________________________________ have agreed to be the Patient Advocate for the person named above.

Patient Advocate

I, ______________________________________________________ have agreed to be the Patient Advocate for the person named above.

First Alternate (Successor) Patient Advocate (Optional)

البديل الأول لمناصر المريض (مناصر المريض اللاحق) (اختياري)

I, ______________________________________________________ have agreed to be the Patient Advocate for the person named above.

First Alternate Patient Advocate

I, ______________________________________________________ have agreed to be the Patient Advocate for the person named above.

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First Alternate Patient Advocate

I, ______________________________________________________ have agreed to be the Patient Advocate for the person named above.

First Alternate Patient Advocate

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First Alternate Patient Advocate

I, ______________________________________________________ have agreed to be the Patient Advocate for the person named above.

First Alternate Patient Advocate

I, ______________________________________________________ have agreed to be the Patient Advocate for the person named above.

First Alternate Patient Advocate
Second Alternate (Successor) Patient Advocate (Optional)

البديل الثاني لمناصر المريض (مناصر المريض اللاحق) (اختياري)

I, _______________________________________ have agreed to be the Patient Advocate for the person named above.

(PRINT)

 أنا، _______________________________________ وافقت على دور مناصر المريض للشخص المذكور أعلاه.

Signature/توقيع: ___________________________ Date/التاريخ: ___________________________

Address/العنوان: ______________________________________________________________________________

City/State/Zip/المدينة/الولاية/الرمز البريدي:

______________________________________________________________________________________________

Telephone: Primary (Cell ) ______________________ Secondary (Cell ) ____________________________

الهاتف: الأساسي (الخليوي ) ______________________ الثانوي (الخليوي ) ____________________________

Making Changes

إجراء تغييرات

If only the contact information for your advocate(s) changes, it may be revised on the original and on the photocopies without replacing the entire form.

فقط إن تغيرت معلومات الاتصال بمناصريك، فقد تجري مراجعة ذلك في الأصل والنسخ الضوئية دون استبدال النموذج كله. النسخ الضوئية لهذا النموذج مقبولة كأصولها.

Photocopies of this form are acceptable as originals.
Preferences for Spiritual/Religious & End of Life Care
التفضيلات الروحانية والدينية ورعاية نهاية الحياة

(This section is optional, but recommended)
(هذا القسم اختياري، ولكن يُوصى به)

Spiritual/ Religious Preferences
التفضيلات الروحانية والدينية

I am of the __________________ faith/belief.

I am affiliated with the following faith/belief group/congregation:
________________________________________________________________________________.

Please attempt to notify my personal clergy or spiritual support person(s) at:
________________________________________________________________________________.

I want my health care providers to know these things about my religion or spirituality that may affect my
physical, emotional or spiritual care: (e.g., spiritual/religious rituals or sacraments, etc.)
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

أنا من ال________________________________________ faith/belief.

أنا أشتمل على الجمعية/الرعاية الدينية/المعتقد:
________________________________________________________________________________

أنا أؤمن في ____________________________________________ . أنا أشتمل إلى

__________________________________________________________.

أرغب في أن يعرف مقدم الرعاية الصحية لي بالأشياء التالية عن ديني أو اعتقادي الروحاني مما قد يؤثر على

رعايةي الدينية أو الانفعالية أو الروحانية: (مثالًا: الطقوس الروحانية/الدينية أو الطقوس الدينية، وما إلى ذلك).

______ I choose not to complete this section.

أختار عدم استكمال هذا القسم.
If possible, at the end of life, I would prefer to be cared for: (either check or rank order all that apply)

___ in my home ___ in a long-term care facility
___ in a hospital ___ as my Patient Advocate thinks best
___ I would like hospice services in any of the above settings or in a hospice residence

In my last days or hours, if possible, I wish the following for my comfort: (e.g.: pain medication, certain music, readings, visitors, lighting, foods, therapy animal, etc.)

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

___ I choose not to complete this section.
Preferences for Anatomical Gift(s)

تفصيلات الهبة (الهبات) التشريحية التبرع بالأعضاء/بالأنسجة/بالجثما

(The section is optional, but recommended)

In this section, you may, if you wish, state your instructions for: organ/tissue donation, autopsy, and anatomical gift.

The authority granted by me to my Patient Advocate regarding organ/tissue donation shall, in compliance with Michigan law, remain in effect and be honored following my death. I understand that whole-body anatomical gift donation generally requires pre-planning and pre-acceptance by the receiving institution.

السلطة التي أمنحها إلى مائلا مناصب المريض الخاص بي بشأن التبرع بالأنظمة/الجثما أن تظل سارية، بما يتفق مع قانون ميشيغان، وينبغي تكريما بعد وفاني، أدرك أن التبرع بالجسم كله كهبة تشريحية يتطلب الاتخاذ المسبوق للقبول المسبق من طرف المؤسسة التي تلتقاه.

Instructions:

• Put your initials (or "X") next to the choice you prefer for each situation below.

• دوّن الحروف الأولى من اسمك (أو "X") إلى جوار الخيار الذي تفضلها لكل موقف أدناه.
Anatomical Gift(s) – Donation of my Organs/Tissue/Body
الهبة(الهبات) التشريحية - التبرع بأعضائي/بأنسجتي/بجسمي

___ I am registered on the Michigan Donor Registry and/or Michigan driver’s license.

By Michigan law, your Patient Advocate and your family must honor your organ donation instructions.

Choose one option:

___ I am not registered, but authorize my Patient Advocate to donate any parts of my body that may be helpful to others {e.g., ORGANS [heart, lungs, kidneys, liver, pancreas, intestines], or TISSUES [heart valve, bone, arteries & veins, corneas, ligaments & tendons, fascia (connective tissue), skin]}

___ I am not registered, but authorize my Patient Advocate to donate any parts of my body, EXCEPT (name the specific organs or tissues):

__________________________________________________________________
__________________________________________________________________

___ I do not want to donate any organ or tissue.

___ I have arranged, or plan to arrange, donating my body to an institution of medical science for research or training purposes (must be arranged in advance).
أنا مسجل ضمن سجل متبرع ميشيغان (Michigan Donor Registry) رخصة قيادة من ميشيغان.

بموجب قانون ميشيغان، فإن مناصر المريض الخاص بك وأسرتك يجب أن يكروا تعليمات تبرع بالأعضاء.

اختر أحد الخيارات:

- لست مسجلًا، ولكنني أفوض مناصر المريض الخاص بي بالتبرع بأي من أجزاء جسمي مما قد يفيد غربى (مثل الأعضاء [القلب والرئتين والكليتين والكبد والتوريد والأوعية والأملاك] أو الأنسجة [القشر الأصفر أو البحر])

- لست مسجلًا، لكنني أفوض مناصر المريض الخاص بي بالتبرع بأي من أجزاء جسمي، باستثناء (حدد الأعضاء أو الأنسجة المحددة):

لا أرغب في التبرع بأي من أعضائي أو أنسجتي.

- أختار رتبت، أو أخطط بالترتيب، للتبرع بجسمي إلى إحدى مؤسسات العلوم الطبية للأبحاث العلمية أو لأغراض التدريب (يجب الترتيب لذلك مسبقاً).

- لأني أختار عدم استكمال هذا القسم.

(continues next page)
Preferences for Anatomical Gift(s)

تفضيلات الهبة (الهبات) التشريحية

Organ/Tissue/Body Donation & Autopsy

tبرع بالأعضاء/بالأنسجة/الجثث والتفصيل بشأن تشريح الجثثان

(This section is optional, but recommended)

(هذا القسم اختياري، ولكن يُؤْوَضُ به)

Instructions:

التعليمات:

• Put your initials (or “X”) next to the choice you prefer for each situation below.
• NOTE: A medical examiner may legally require an autopsy to determine cause of death. Other autopsies may be elected by next of kin (possibly at family expense).

• دوَّنِ الحروف الأولى من اسمك (أو «X») إلى جوار الخيار الذي تفضله لكل موقف أدناه.
• ملحوظة: للطبيب الشرعي أن يطلب بتشريح الجثثان لتحديد سبب الوفاة. ويمكن اختيار أي تشريح آخر لجثمان بواسطة أقرب الأقارب (يستحب أن يكون ذلك على نفقة العائلة).

Autopsy Preference

تفضيل تشريح الجثثان

I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future health care decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

If optional, I do not want an autopsy performed on me.

أقبل بتشريح الجثثان إن كان ذلك يساعد أقرباء دمي على فهم سبب وفاني أو إن كان يساعدهم في قرارات الرعاية الصحية المستقبلية الخاصة بهم.

_____ أقبل تشريح الجثثان إن كان ذلك يساعد على تقدم الطب أو التعليم الطبي.

إن كان ذلك اختياريًا فلا أرغب في تشريح جثثاني.

_____ I choose not to complete this section.

أختار عدم استكمال هذا القسم.
Preferences for Mental Health Examination & Treatment
التفضيلات المتعلقة بفحص وعلاج الصحة العقلية

(Optional)
اختياري

A determination of my inability to make decisions or provide informed consent for mental health treatment will be made by

________________________________________________________.

(Physician/Psychiatrist)

تقرير عدم قدرتي على اتخاذ القرارات أو تقديم موافقة مستنيرة على علاج الصحة العقلية سيقوم بـ

________________________________________________________

(النفسي/الاختصاصي النفسي)

____ I choose not to complete this section.

____ أختار عدم استكمال هذا القسم.
I expressly authorize my Patient Advocate to make decisions concerning the following treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care. (initial one or more choices that match your wishes)

____ outpatient therapy
____ voluntary admission to a hospital to receive inpatient mental health services

I have the right to give three days' notice of my intent to leave the hospital

*____ Involuntary admission to a hospital to receive inpatient mental health services
*____ psychotropic medication
*____ electro-convulsive therapy (ECT)

*____ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days' notice of my intent to leave a hospital if I am a formal voluntary patient.

*Choices with an asterisk require your express permission to your Patient Advocate(s) prior to treatment/action.

I have specific wishes about mental health treatment, such as a preferred mental health professional, hospital or medication. My wishes are as follows:

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

(Sign your name if you wish to give your Patient Advocate this authority) Date
I choose not to complete this section.
Treatment Preferences (Goals of Care)

تفضيلات العلاج (أهداف الرعاية)

(This section is optional, but recommended)

(هذا القسم اختياري، ولكن يُوصى به)

Print Name/Date of Birth/Address: ____________________________________________________________

Specific Instructions to my Patient Advocate

تعليمات محددة لمناصر المريض الخاص بي

When I am not able to decide or speak for myself, the following are my specific preferences and values concerning my health care:

إِنِّي لم أَكَمُ قَدِيرًا عَلَى اخْتَلَافِ الْمَوْقِعَاتِ وَالْعَمَلِيَّةَ، فَهُمُ عِنْ وَقَالِ، فَفَعَّلْتُهُ وَقَالَهُ فَمَا أَخْبَثَ الْحَقَّ وَقَالَهُ فيَفْتَرَى قَدِيرًا عَلَى اخْتَلاَفِ الْمَوْقِعَاتِ وَالْعَمَلِيَّةَ.

Instructions:

• Put your initials (or “X”) next to the choice you prefer for each situation below.

ٍدَوّْنِ الحروف الأولى من اسمك (أو “»”) إلى جوار الخيار الذي تفضل له كل موقف أدنائه:

Treatments to Prolong my Life

العلاجات التي تطيل حياتي

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, where I am, and I am unable to meaningfully interact with others:

___ I want all possible efforts to prolong life made on my behalf, even if it means I may remain on life-sustaining equipment, such as a breathing machine or kidney dialysis, for the rest of my life.

OR

___ I want my health care providers to try treatments to prolong my life for a period of time. If these treatments are not helping me get better, are not going to improve my current condition, or if they are causing me pain and suffering, then I want to stop these treatments.

OR

___ I do not want to start treatments to prolong my life; if treatments have begun, please stop.

Medications and treatment intended to provide comfort or pain relief shall not be withheld or withdrawn.
I choose not to complete this section.

Refer to my additional documents regarding my treatment preferences.
Cardiopulmonary Resuscitation (CPR)

This is NOT a "Do Not Resuscitate" (DNR) Medical Order. A DNR medical order is a separate legal document.

CPR is an attempt to restart your heart and breathing. It could include pressing hard on your chest to try to restart your heart and placing a tube into your windpipe to connect to the breathing machine. Electric shock to your heart and medications to support your heart may be included.

Instructions:

• Initial of place an "X" next to your choice.

If my heart and breathing stops:

____ I want the healthcare team to try CPR in all cases.

OR

____ I want CPR unless my health care providers determine that I have any of the following:

• An injury or illness that cannot be cured and I am dying.

• No reasonable chance of surviving the CPR attempt.

• Little chance of surviving long term, and it would be hard and painful for me to recover from CPR.

OR

____ I do not want CPR but instead want to allow natural death.

General Feelings/Preferences

This is NOT a "Do Not Resuscitate" (DNR) Medical Order. A DNR medical order is a separate legal document.
I choose not to complete this section.

Additional Specific Instructions

I want my Patient Advocate to follow these specific instructions, which may limit the authority previously described in General Instructions to My Patient Advocate.

I choose not to complete this section.

Signature

If you are satisfied with your choice of Patient Advocate and with the Treatment Preferences guidance you have provided in this section, you need to sign and date the statement below.

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind. These are my preferences and goals expressed and affirmed on the date below:

Signature: _________________________________________
Date: ____________________________________________