What Now?

Now that you have completed your Advance Directive, you should also take the following steps:

- Tell the person you named as your Patient Advocate, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future. Have your Patient Advocate sign the Patient Advocate form ***as soon as possible!***
- Talk to the rest of your family and/or close friends who might be involved if you have a serious illness or injury. Make sure they know your wishes and the names of your Patient Advocate(s).
- Make sure your wishes are understood and will be followed by your doctor or other health care providers.
- Keep a copy of your Advance Directive where it can be easily found (do NOT place it in a safe deposit box!).
- If you go to a hospital or a nursing home, take a copy of your Advance Directive with you and ask that it be placed in your medical record.

Review your Advance Directive every time you have an annual physical exam or whenever one of the "Five D's" occur:

Decade – when you start each new decade of your life.
Death – whenever you experience the death of a loved one.
Divorce – if you (or your Patient Advocate) experience a divorce or other major family change.
Diagnosis – if you are diagnosed with a serious health condition.
Decline – if you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

Upon your request, a copy will also be sent to any other physician or healthcare facility providing care to you. *Photocopies of an Advance Directive may be relied upon as though they were originals.*

Who holds a copy of this Advance Directive?

Healthcare Providers:

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

Hospital System Medical Records Department:

Name: _____

Others (e.g. family members, friends, clergy, attorney):

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

Contact Name: _____ Phone _____

Address: _____

I have authorized my Advance Directive to be registered with

❑ *Great Lakes Health Connect* ❑ _____