

## RESOURCES

### Want to Learn More or Share Online Resources With Your Family and Friends?

The Lung Patient Education Guide (this book) can be found electronically on the Michigan Medicine Transplant Center website at <http://www.uofmhealth.org/medical-services/transplant/lung-transplant-patient-care-guide>.

The Michigan Medicine Transplant Center provides educational videos about lung transplant that were developed to answer many of the common questions patients and family members raise leading to and during the course of care. These videos can be found online at <http://www.uofmhealth.org/medical-services/transplant/lung-transplant-videos>.

For general information about the Michigan Medicine Transplant Center, please visit [www.uofmhealth.org/transplant](http://www.uofmhealth.org/transplant).

### Michigan Medicine Patient Portal

#### *What is MyUofMHealth.org?*

**MyUofMHealth.org** offers patients personalized and secure online access to portions of their medical records. It enables you to securely use the Internet to help manage and receive information about your health. With **MyUofMHealth.org**, you can use the Internet to:

- Request medical appointments.
- View your health summary from the **MyUofMHealth.org** electronic health record.
- View test results.
- Request prescription renewals.
- Access trusted health information resources.
- Communicate electronically and securely with your medical care team.

#### *How Do I Sign Up?*

Patients who wish to participate will be issued a **MyUofMHealth.org** activation code. There are two ways to get an activation code. Patients can get an activation code after their clinic visit or they can request an activation code by completing the online request form located on the **MyUofMHealth.org** website. This code will enable you to login and create your own username and password.

#### *Who Do I Contact if I Have Further Questions?*

You may e-mail [HIM-PatientPortal@med.umich.edu](mailto:HIM-PatientPortal@med.umich.edu), or you can call the Health Information Management Department at (734) 615-0872 Monday-Friday, 8 am-5 pm.

## Raising Funds to Cover Medical Expenses

If the out-of-pocket costs seem to be more than you would be able to afford, you may wish to consider raising funds to help cover the medical costs. Organizations are available to assist you and your family with fundraising for medical treatments. They often have information designed to help families with the process. The contact information for some of the organizations that work with transplant patients and families is shown below.

- **Help Hope Live**  
Two Radnor Corporate Center  
100 Matsonford Road, Suite 100  
Radnor, PA 19087  
(800) 642-8399 toll-free  
(610) 535-6106 fax  
<https://helphopelive.org>
- **Children's Organ Transplant Association**  
2501 West COTA Drive  
Bloomington, Indiana 47403  
(800) 366-2682 toll-free  
(812) 336-8885 fax  
[www.cota.org](http://www.cota.org)
- **National Foundation for Transplants**  
5350 Poplar Avenue, Suite 850  
Memphis, Tennessee 38119  
(800) 489-3863 toll-free  
(901) 684-1128 fax  
[www.transplants.org](http://www.transplants.org)



## Transplant-Related Websites

- **University of Michigan Transplant Center**  
**[www.uofmhealth.org/transplant](http://www.uofmhealth.org/transplant)**

The official website of the University of Michigan Transplant Center geared to provide patients with information regarding the Transplant Center and the transplant process for all solid organ programs.

- **Scientific Registry of Transplant Recipients (SRTR)**  
**[www.srtr.org](http://www.srtr.org)**

The Scientific Registry of Transplant Recipients (SRTR) provides ongoing research to evaluate information and tracks all transplant patients from the time of transplant through discharge, then annually, until graft failure or death.

- **United Network for Organ Sharing (UNOS)**  
**[www.unos.org](http://www.unos.org)**

United Network for Organ Sharing is a non-profit, scientific, and educational organization that administers the Organ Procurement and Transplantation Network (OPTN), collects and maintains its data, and serves the transplant community.

- **Gift of Life Michigan (GOLM)**  
**[www.giftoflifemichigan.org](http://www.giftoflifemichigan.org)**

Gift of Life Michigan is the only non-profit full-service organ and tissue recovery agency in Michigan since 1971. As an organization, Gift of Life Michigan acts as an intermediary between the donor hospital and the recipient transplant center providing all the services necessary for organ, tissue and eye donation.

- **Transplant Living**  
**[www.transplantliving.org](http://www.transplantliving.org)**

Transplant Living is a website supported by the United Network for Organ Sharing and is promoted as your prescription for transplant information.

- **Organ Procurement and Transplantation Network (OPTN)**  
**[www.optn.transplant.hrsa.gov](http://www.optn.transplant.hrsa.gov)**

The Organ Procurement and Transplantation Network (OPTN) is a unique public-private partnership that is committed to improving the effectiveness of the nation's organ procurement, donation and transplantation system.

## Support Groups, Community Resources and Sources of More Information

### *Michigan Support Groups:*

#### **Michigan Medicine**

Ann Arbor, MI

Room 2C224 UH, 2nd Floor University Hospital

Meets 3rd Saturday, 10:00 am-12:00 pm

Contact: Amy Van Zee, LMSW: (800) 333-9013 or [avanzee@med.umich.edu](mailto:avanzee@med.umich.edu) or

Stephanie Zaiantz, LMSW: (800) 333-9013 or [szaiantz@med.umich.edu](mailto:szaiantz@med.umich.edu)

Please call or email for an updated schedule.

#### **Friends for Life Support Group – Flint**

Not currently meeting, but call for updates

Contact: Connie Ayres: (810) 397-7970

#### **Henry Ford Hospital – Detroit**

Lung Transplant Support Group

2799 W. Grand River Blvd.

Education and Research Building – Multipurpose Room 1

Detroit, MI 48202

Meets 2nd Wednesday, 1-2:30 pm

Contact: Dr. Bryce: (313) 916-3087

#### **Transplant Support Group**

Spectrum Health

2902 Bradford NE, First Floor

Meets 2nd Monday, 6-7:30 pm

Contact: Amber Lewandowski, LMSW; Jacquie Oliai, NP;

Misty Sligh, LMSW: (616) 391-2802

#### **St. John Transplant Support Group – Detroit**

Contact: (313) 343-3047

Please call for details.

#### **Transplant Support Group of Northern Michigan – Gaylord**

Otsego Memorial Hospital

Professional Medical Building – Conference Room

Contact Bev Cherwinski for details: (989) 983-4188 or [bevo@core.com](mailto:bevo@core.com)

*Local Michigan Resources:*

**Gift of Life Michigan**

3861 Research Park Dr.

Ann Arbor, MI 48108

(800) 482-4881

[www.gifttolifemichigan.org](http://www.gifttolifemichigan.org)

**Lions of Michigan Service Foundation**

5730 Executive Drive

Lansing, MI 48911

(517) 887-6640

Email: [info@lmsf.net](mailto:info@lmsf.net)

[www.lmsf.net](http://www.lmsf.net)

**Michigan Rehabilitation Services**

201 N. Washington Sq., 4th Floor

Lansing, MI 48933

(517) 373-3390

(800) 605-6722

**Pure Michigan Talent Connect (Previously Michigan Works!)**

Job seekers can post their resumes in Michigan's Talent Bank and look for job openings in Michigan's Job Bank. (800) 285-WORKS [www.mitalent.org](http://www.mitalent.org)

**Second Chance at Life**

PO Box 85087

Westland, Michigan 48185

(734) 748-9690

[www.secondchanceatlife.org](http://www.secondchanceatlife.org)

*National Resources:*

**American Association of Sex Educators, Counselors, and Therapists (AASECT)**

To find a local sex therapist, visit [www.aasect.org](http://www.aasect.org).

**American Diabetes Association**

300 Galleria Officentre, Suite 111  
Southfield, MI 48034  
(248) 433-3830 or (800) 342-2383

**American Kidney Fund**

11921 Rockville Pike, Suite 300  
Rockville, MD 20852  
(800) 638-8299  
[www.kidneyfund.org](http://www.kidneyfund.org)  
Email: [helpline@kidneyfund.org](mailto:helpline@kidneyfund.org)

**American Lung Association**

55 W. Wacker Dr., Suite 1150  
Chicago, IL 60601  
312-801-7630  
(800) LUNGUSA  
[www.lung.org](http://www.lung.org)

**American Organ Transplant Association**

P.O. Box 418  
Stilwell, KS 66085  
(713) 344-2402  
[www.aotaonline.org](http://www.aotaonline.org)

**The Healthwell Foundation**

PO Box 4133  
Gaithersburg, MD 20885  
(800) 675-8416  
[www.healthwellfoundation.org](http://www.healthwellfoundation.org)

**Second Wind Lung Transplant Association, Inc.**

Toll Free Help Line: (888) 855-9463  
[www.2ndwind.org](http://www.2ndwind.org)

**Transplant Recipients International Organization**

(800) TRIO-386

[www.trioweb.org](http://www.trioweb.org)

**United Network for Organ Sharing (UNOS)**

P.O. Box 2484

Richmond, VA 23218

1-888-894-6361

[www.unos.org](http://www.unos.org)

*Disease Specific Websites:*

**Alpha -1 Foundation**

[www.alpha1.org](http://www.alpha1.org)

**Coalition for Pulmonary Fibrosis**

[www.coalitionforpf.org](http://www.coalitionforpf.org)

**Cystic Fibrosis Foundation**

[www.cff.org](http://www.cff.org)

**Efforts (Emphysema Foundation For Our Right To Survive)**

[www.emphysema.net](http://www.emphysema.net)

**Michigan Pulmonary Disease Community Inc.**

[www.mpdci.org](http://www.mpdci.org)

**Pulmonary Hypertension Association**

[www.phassociation.org](http://www.phassociation.org)

**Quest for Breath**

[questforbreath@umich.edu](mailto:questforbreath@umich.edu)

866-860-0026

Pulmonary Fibrosis Support

[www.questforbreath.org](http://www.questforbreath.org)

**Sarcoid Networking Association**

[www.sarcoidosisnetwork.org](http://www.sarcoidosisnetwork.org)

**The LAM foundation**

[www.thelamfoundation.org](http://www.thelamfoundation.org)







# Durable Power of Attorney for Health Care (DPOA-HC)

## CHOOSE A PATIENT ADVOCATE

I, ..... (print your name),  
living at....., and being of sound  
mind, voluntarily choose a Patient Advocate to make care, custody, and medical treatment decisions for me. This durable  
power of attorney for health care is only effective when I am unable to make my own medical decisions. I understand I  
may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

I want the person named below to be my Patient Advocate and to be able to make medical decisions for me when I cannot  
make them myself. I have talked to my advocate(s) and have provided them with a copy of this directive.

## PATIENT ADVOCATE

Name..... Relationship .....

Address..... City..... State ..... Zip .....

Telephone Number.....

If that person is not available, or cannot serve, I want this person to be my **FIRST ALTERNATE PATIENT ADVOCATE.**

Name..... Relationship .....

Address..... City..... State .....

Telephone Number.....

If that person is not available, or cannot serve, I want this person to be my **SECOND ALTERNATE PATIENT ADVOCATE.**

Name..... Relationship .....

Address..... City..... State ..... Zip .....

Telephone Number.....

**PROVIDERS: PLEASE RETAIN A COPY OF ALL PAGES FOR THE MEDICAL RECORD.**

## GUIDELINES WORKSHEET

### *Life Support*

Some people want to decide what types of life support treatments and medicines they get from doctors to help them live longer when they are sick. Read through all six choices and initial the one that best fits what you want or do not want to happen if you are very sick.

- ..... I want doctors to do everything they think might help me. Even if I am very sick and I have little hope of getting better,  
*I want them to keep me alive for as long as they can.*
- ..... I want doctors to do everything they think might help me, but, if I am very sick and I have little hope of getting better,  
*I do NOT want to stay on life support.*
- ..... I want doctors to do everything they think might help me, but (*initial all that apply*):
  - ..... I don't want doctors to restart my heart if it stops by using CPR.
  - ..... I don't want a ventilator to pump air into my lungs if I cannot breathe on my own.
  - ..... I don't want a dialysis machine to clean my blood if my kidneys stop working.
  - ..... I don't want a feeding tube if I can't swallow.
  - ..... I don't want a blood transfusion if I need blood.
- ..... I don't want any life support treatment.
- ..... I want my Patient Advocate to decide for me.
- ..... I am not sure.
- ..... Other .....

### *What Makes Life Worth Living?*

Think about what makes life worth living for you. For example, being able to talk to your loved ones, being able to take care of yourself, or being able to live without being hooked up to machines. Under what circumstances would you say life is NOT worth living? (*initial all that apply*)

- ..... If I will most likely not wake up from a coma.
- ..... If I can't take care of myself.
- ..... If I am in pain.
- ..... If I cannot live without being hooked up to machines.
- ..... I am not sure.
- ..... Other .....

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***You must read and SIGN the following statement if you want to give your Patient Advocate the power to make medical decisions that might let you die when you are very sick:***

I want my Patient Advocate named in this form to make decisions about life support and treatments that would allow me to die when I am very sick. When making those decisions, I want my Patient Advocate to follow the guidelines I have provided.

.....  
Your Signature

.....  
Date

## **POWER REGARDING MENTAL HEALTH TREATMENT (OPTIONAL)**

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 (*check one or more consistent with your wishes*):

- ☐ Outpatient therapy
- ☐ My admission as a formal voluntary patient 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.
- ☐ My 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.

***You must read and SIGN the following statement if you want to give your Patient Advocate the power to make decisions about your mental health care and treatment:***

I want my Patient Advocate named in this form to make decisions about my mental health care and treatment. When making those decisions, I want my Patient Advocate to follow the guidelines I have provided.

.....  
Your Signature

.....  
Date

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## END OF LIFE PLANS

If you are dying, where would you like to be? At home? In the hospital? With only your family? With a religious or spiritual leader?

.....

.....

.....

.....

### What Happens to Your Body After Death?

You may choose to donate your organs. If you let your Patient Advocate donate your organs, he or she will be able to make that decision only after your death.

..... I want to donate ALL of my organs.

..... I want to donate ONLY THESE organs:

.....

.....

..... I do NOT want to donate any of my organs.

..... I want my Patient Advocate to decide.

..... I am not sure.

### Religion

Some religions do not allow certain treatments or medicines. If there are treatments that you do not want to have because of your religion, please write them down here.

.....

.....

.....

.....

### Other Guidelines

Write down any other guidelines or thoughts you think might help you Patient Advocate or doctor decide what kind of health care you want.

.....

.....

.....

.....

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**Liability**

It is my intent that no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my Patient Advocate. Photocopies of this form can be relied upon as though they were originals.

**YOUR SIGNATURE**

I want the people I selected in the “Choose a Patient Advocate” section to be my Patient Advocate and Alternate Patient Advocate(s). I understand that this will let them make medical decisions for me when I cannot. I am making this decision because this is what I want, **NOT** because anyone forced me to.

Your Signature .....Date.....

PRINT your name.....

Address..... City..... State ..... Zip.....

**STATEMENT REGARDING WITNESSES**

I have chosen two adult witnesses who are not my spouse, parent, child, grandchild, brother or sister, and are not my presumptive heir or beneficiary at the time of witnessing. My witnesses are not my Patient Advocate(s). They are not my physician, or an employee of a health facility that is treating me; not an employee of my life or health insurance provider, or of a home for the aged where I reside, nor of a community mental health services program or hospital that is providing mental health services to me.

**STATEMENT AND SIGNATURE OF WITNESSES**

We sign below as witnesses. This Declaration was signed in our presence. The **PERSON SIGNING APPEARS** to be of sound mind, and to be making this designation voluntarily, without duress, fraud, or undue influence.

.....  
Witness signature Date

.....  
Witness signature Date

.....  
PRINT Witness's name

.....  
PRINT Witness's name

.....  
Witness's telephone number

.....  
Witness's telephone number

**PROVIDERS: PLEASE RETAIN A COPY OF ALL PAGES FOR THE MEDICAL RECORD.**

# DURABLE POWER OF ATTORNEY FOR HEALTH CARE

## ACCEPTANCE BY PATIENT ADVOCATE

I, .....(insert Patient Advocate's Name),  
agree to be the Patient Advocate for .....(insert Patient's Name).

*I accept the patient naming me Patient Advocate and I understand and agree to take reasonable steps to follow the desires and instructions of the patient. I also understand and agree that:*

- (A) **This designation is not effective unless** the patient is unable to participate in medical or mental health treatment decisions.
- (B) **A Patient Advocate shall not exercise powers** concerning the patient's care, custody, and 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) **A Patient Advocate CANNOT exercise powers for a pregnant patient** to withhold or withdraw treatment or make medical treatment decisions that would result in the pregnant patient's death.
- (D) **A Patient Advocate may make a decision to withhold or withdraw treatment** that 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 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.
- (F) **A Patient Advocate shall 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.
- (G) **A patient may revoke his or her designation** at any time and in any manner sufficient to communicate an intent to revoke.
- (H) **A patient may waive his or her right to revoke the designation** as to the power to make mental health treatment decisions and, if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for up to 30 days.
- (I) **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.
- (J) **A patient admitted to a health facility or agency has the rights** enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being section 333.20201 of the Michigan Compiled Laws.
- (K) **If the patient has designated the Patient Advocate to make an organ or body donation**, that authority will remain after the patient's death.

.....  
Patient Advocate's Signature

.....  
Date

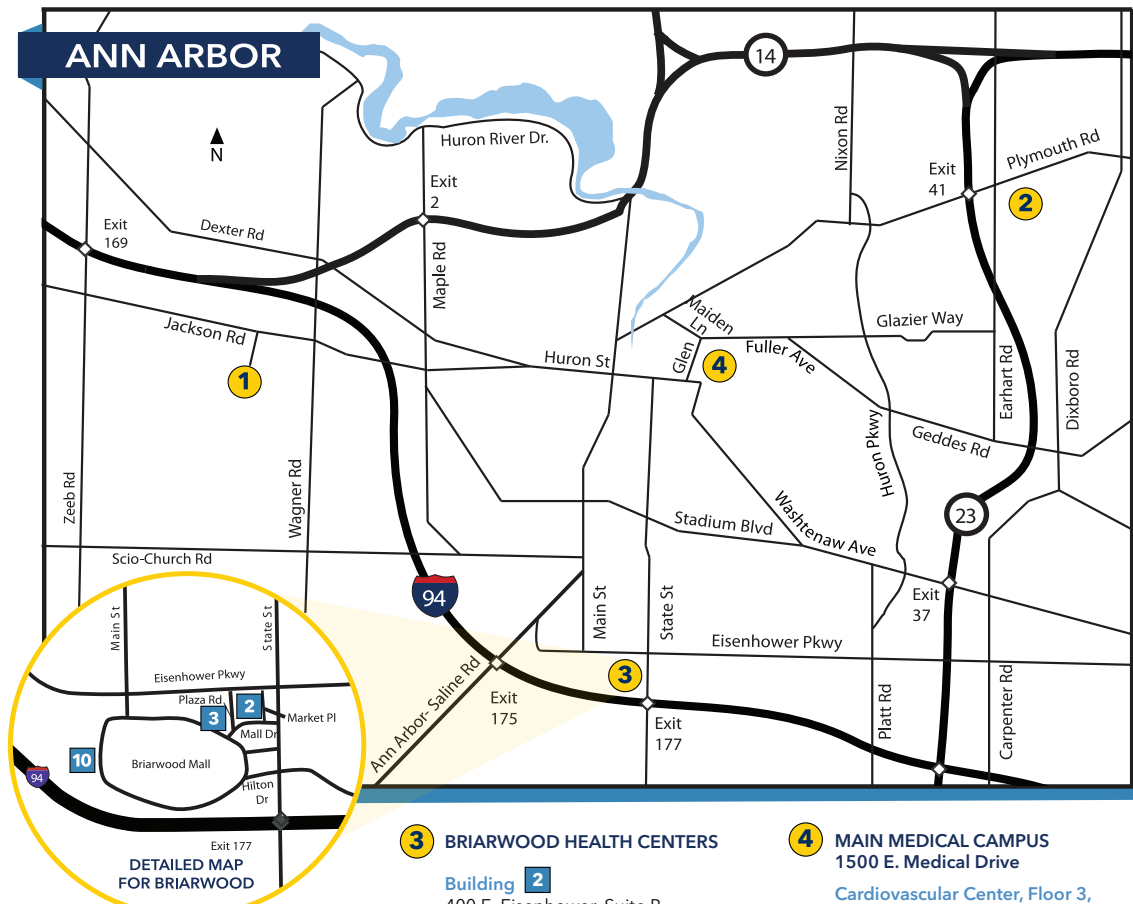
**PROVIDERS: PLEASE RETAIN A COPY OF ALL PAGES FOR THE MEDICAL RECORD.**

## MLABS BLOOD DRAWING LOCATIONS



MLabs offers adult and pediatric blood drawing services through Michigan Medicine. No appointment is necessary for routine services except for the Howell Health Center location; please call ahead to schedule glucose tolerance testing. Hours are subject to change without notice. Please do not contact the specimen collection facility or blood drawing station for test result information.

Questions? 800.862.7284 or [mlabs.umich.edu](http://mlabs.umich.edu)



### 1 WEST ANN ARBOR HEALTH CENTER

380 Parkland Plaza, Suite 130

**Ph:** 734.232.9720 **Fax:** 734.232.9772

Mon-Th 7am - 7pm  
Fri 7am - 5pm  
Sat 8am - Noon

### 2 EAST ANN ARBOR HEALTH CENTER

4260 Plymouth Rd.

**Ph:** 734.647.5685 **Fax:** 734.647.6457

Mon-Th 7am - 7:30pm  
Fri 7am - 5:30pm  
Sat 8am - 12:30pm

### 3 BRIARWOOD HEALTH CENTERS

#### Building 2

400 E. Eisenhower, Suite B

**Ph:** 734.998.4413 **Fax:** 734.647.3718

Mon- Fri 8am - 3:30pm

#### Building 3

375 Briarwood Circle

**Ph:** 734.998.0284 **Fax:** 734.998.6502

Mon-Fri 7am - 2:30pm

(Closed 1st Tuesday of each month 8am - 10:30am)

#### Building 10

1801 Briarwood Circle

**Ph:** 734.913.0167 **Fax:** 734.998.4489

Mon-Fri 9:30am - 5:00pm

(Closed 2nd Wednesday of each month 8am - 1pm)

### 4 MAIN MEDICAL CAMPUS

1500 E. Medical Drive

**Cardiovascular Center, Floor 3, Reception A**

**Ph:** 734.232.5111 **Fax:** 734.232.5130

Mon-Fri 7am - 6pm

**Children's & Women's Hospital, Reception B**

**Ph:** 734.232.5672 **Fax:** 734.232.5682

Mon-Fri 7am - 6pm

**Cancer Center, Floor B2, Reception E**

**Ph:** 734.647.8913 **Fax:** 734.647.8937

Mon-Fri 7am - 6pm

**Taubman Center, Floor 1, Reception D**

**Ph:** 734.647.6304 **Fax:** 734.647.6779

Mon-Fri 7am - 7pm

Sat 8am - Noon

**Taubman Center, Floor 2, Reception H**

**CLOSED**

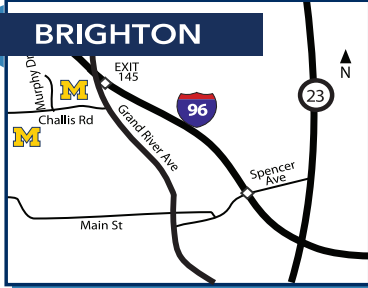
**Taubman Center, Floor 3**

**Ph:** 734.936.6760 **Fax:** 734.936.7419

Mon-Fri 7am - 6pm

## MLABS BLOOD DRAWING LOCATIONS

### BRIGHTON



**BRIGHTON HEALTH CENTER**  
8001 Challis Road

**P:** 810.494.2649  
**F:** 810.494.2645

Mon - Th 7am - 7pm  
Fri 7am - 5pm

**BRIGHTON CENTER FOR SPECIALTY CARE**  
7500 Challis Road

**P:** 810.263.4087  
**F:** 810.263.4090

Mon - Fri 7am - 6pm  
Sat 7am - 4pm

### CANTON • LIVONIA • NORTHVILLE



**LIVONIA HEALTH CENTER**  
20321 Farmington Rd

**P:** 248-473-4350  
**F:** 248-888-1390

Mon-Fri 8am - 3:30pm

**NORTHVILLE HEALTH CENTER**  
39901 Traditions Dr  
(at 7 Mile & Haggerty)

**P:** 248-305-4640  
**F:** 248-305-4642

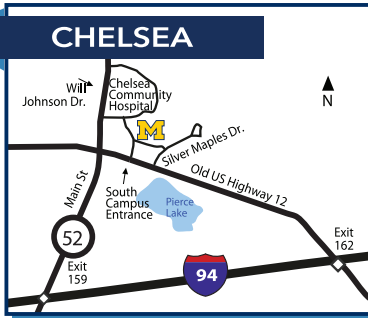
Mon - Th 7am - 6:30pm  
Fri 7am - 5pm  
Sat 8am - Noon

**CANTON HEALTH CENTER**  
1051 North Canton Center Rd

**P:** 734.844.5280  
**F:** 734.844.5288

Mon - Th 7am - 7:30pm  
Fri 7am - 5pm  
Sat 8am - Noon

### CHELSEA

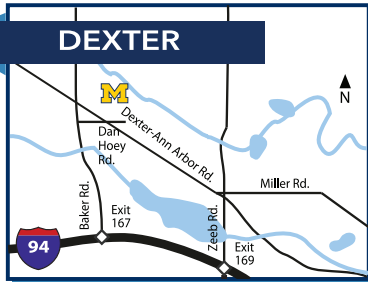


**CHELSEA HEALTH CENTER**  
14700 E. Old U.S. 12

**P:** 734.475.4483  
**F:** 734.433.4246

Mon - Fri 8am - 3:30pm  
Sat 8am - Noon

### DEXTER

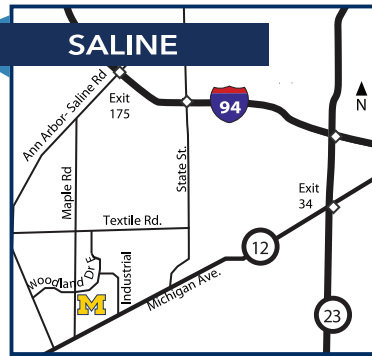


**DEXTER HEALTH CENTER**  
7300 Dexter-Ann Arbor Rd

**P:** 734.426.1724  
**F:** 734.426.2707

Mon - Fri 8am - 3:30pm

### SALINE

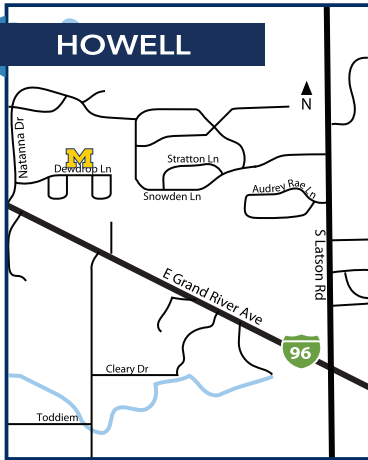


**SALINE HEALTH CENTER**  
700 Woodland Dr E

**P:** 734.295.0022  
**F:** 734.429.1156

Mon-Fri 8am - 3:30pm

### HOWELL

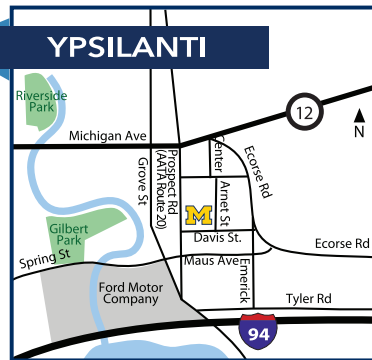


**HOWELL HEALTH CENTER**  
3399 E Grand River Ave

**P:** 517.338.2058  
**F:** 517.540.0203

Mon - Fri 8am - 3:30pm  
BY APPOINTMENT ONLY

### YPSILANTI



**YPSILANTI HEALTH CENTER**  
200 Arnet St  
(entry drive off Davis St)

**P:** 734.544.3277  
**F:** 734.544.3272

Mon - Fri 9am - 5pm





## LUNGTRANSPLANTATION PROGRAM

# Patient and Caregiver Agreement

Name: \_\_\_\_\_  
MRN: \_\_\_\_\_  
DOB: \_\_\_\_\_

I, \_\_\_\_\_, am being considered as a candidate for lung transplantation at Michigan Medicine. My adult caregiver(s) and I understand the following agreement. We also understand that failure to follow this agreement could result in poor health outcomes before or after transplant:

- 1) I will follow all medical advice given to me by my Michigan Medicine providers including taking all medications as prescribed, keeping all appointments for diagnostic testing and treatment at Michigan Medicine and other providers, and informing the transplant program about any new medical, social, financial (including change in insurance coverage), or transportation concerns that may impact my medical care and future transplant.
- 2) I understand that lung disease can worsen over time and it is necessary to have someone living with me for some period of time as mandated by the transplant team prior to transplant, and for a substantial time period after the transplant as deemed necessary by the transplant team.
- 3) I understand it is necessary to develop an adequate social support plan both before and after my transplant to increase my chances of a successful outcome. If my support plan changes I will notify the Transplant Center at **(800) 333-9013** and ask to speak with my social worker. I understand that having a support plan and a signed Patient and Caregiver Agreement are requirements to be on the waiting list for a lung transplant at the University of Michigan.
- 4) I have one or more caregiver(s) who have committed to help me during the waitlist period and recovery after my lung transplant. We understand that the responsibilities of my primary caregiver(s) are:
  - To accompany me to Michigan Medicine for my appointments before and after transplant.
  - To work with staff at Michigan Medicine on my behalf, if I am medically unable to do so.
  - To provide 24-hour care after discharge from my transplant surgery for as long as recommended by transplant team (typically 6 weeks or more).
  - To provide transportation to Michigan Medicine for surgery, urgent care needs, weekly clinic visits and lab draws.
  - To support me during my hospital stay and to participate in inpatient education, discharge instructions, adherence to my medication regimen, and follow-up with my Michigan Medicine appointments.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Caregiver Signature (required) \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Other Caregiver Signature (not required) \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Worker's Signature \_\_\_\_\_

**Michigan Transplant Center Policy #523****Policy on Substance Abuse****I. POLICY STATEMENT**

(None.)

**II. PURPOSE**

The purpose of this policy is to provide a framework for referring lung transplant candidates to substance abuse treatment programs.

**III. DEFINITIONS**

None.

**IV. STANDARDS****Policy on Substance Abuse**

- A. The University of Michigan Lung Transplant Program requires that patients agree to completely abstain from tobacco and all illicit substances.
1. Illicit substances include cannabis (marijuana), cocaine, heroin, and any controlled substance that has not been prescribed by a physician. Using any form of tobacco or cannabis is improper under this policy. This includes cigarettes, cigars, snuff, and chewing tobacco. Because of the harmful effects of nicotine, the use of any nicotine replacement via patch, gum, electronic cigarettes, vaporizers, etc. is prohibited.
  2. Patients may be required to abstain from other legal addictive substances as determined by the Lung Transplant team. This includes but is not limited to alcohol, over the counter medication, and prescribed medications (narcotics, benzodiazepines). This includes zero tolerance for marijuana, including medical marijuana prescribed by a physician. The abuse of alcohol in any form is improper under this policy.
- B. Patients are expected to have a period of abstinence of at least six months from use and formal treatment before transplant listing or activation.
- C. Criteria for referring patients to substance abuse treatment includes but is not limited to:
1. A positive toxicology screen for substances as described above
  2. Daily alcohol use and/or negative consequences associated with alcohol consumption. Reports of daily use will be closely screened to determine if negative consequences are present.
- Negative consequences include but are not limited to:
- a) Minor in possession
  - b) Driving under the influence (DUI) or while impaired (DWI)
  - c) Loss of job due to use
  - d) Failed attempts at sobriety
  - e) Physical complications due to use
  - f) Family history of alcoholism
  - g) Financial stress due to use
  - h) Family/friends report concern about use
  - i) Behavior consistent with substance abuse or addiction as determined by interviews conducted by the transplant team
3. If patient meets criteria, substance abuse treatment resources will be provided. It is the responsibility of the patient to initiate treatment, sign release of information, and provide counselor's contact information to the Lung Transplant Social Worker. The Lung Transplant Social Worker will communicate with patients' substance abuse counselor and report back to the Lung Transplant team.
- Appropriate substance treatment includes but is not limited to:
- a) Therapist with a certification in chemical dependence
  - b) Outpatient treatment substance abuse treatment center
4. Written proof of treatment plan and sobriety are required.

## V. EXHIBITS

### A. Content of Tobacco, Alcohol, and Substance Abuse Contract ([go to print version](#))

The University of Michigan Lung Transplant Program requires that patients agree to abstain completely from tobacco and addictive illicit substances. Illicit substances include cannabis (marijuana), cocaine, heroin, and any controlled substance including medical marijuana even if it has been prescribed by a physician. As a lung transplant candidate, I also understand that use of tobacco in any form is strictly prohibited under this policy. This includes cigarettes, cigars, snuff, and chewing tobacco. Because of the harmful effects of nicotine, I understand that I cannot use any nicotine replacement via patch, gum, electronic cigarettes, vaporizers etc. I also understand that I will be evaluated for abuse of all addictive substances on an ongoing basis. I understand that I may be expected to abstain completely from legal addictive substances, such as alcohol and prescribed (narcotic pain medications, benzodiazepines) or over the counter medication, as determined by the transplant team. I may be expected to have a period of time that I comply with this policy before being listed or activated on the transplant list. When requested, patients accepted for lung transplantation must agree to undergo random urine or blood testing for alcohol, addictive substances, and/or tobacco. Refusal to undergo such a test will be treated the same as a positive test: the patient will be removed from the transplant list.

Patients determined to be abusing alcohol must be certain they do not ingest alcohol of any kind, including cough medicines, over the counter medications containing alcohol, or "alcohol free" beer that contain small amounts of alcohol. If any patient being evaluated as a potential lung transplant recipient, or waiting for a transplant on the University of Michigan transplant list is found to have \*used and/or abused addictive substances, the patient will not be listed or will be removed from the list. A positive test for addictive substances or tobacco in the patient's blood or urine will be considered absolute evidence that the patient has violated the substance abuse policy. A conviction for driving while intoxicated or impaired will similarly be considered to be a violation of this policy.

I have read the above policy and agree to follow these conditions. Questions about the policy have been answered to my satisfaction, and I understand the meaning of the policy. I have been given a copy of this policy for future reference.

In addition, I agree to participate in substance abuse treatment if recommended by the Lung Transplant team. I will be provided a comprehensive list of treatment programs and I understand it is my responsibility to initiate treatment. I will provide the lung transplant social worker information regarding my treatment program, including name and phone number of my counselor.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

I have explained the above policy to the patient and answered any questions they asked.

\_\_\_\_\_  
(Social Worker signature) (phone #) Date \_\_\_\_\_

\* With respect to alcohol, this applies only to potential recipients who have previously been determined to be abusing alcohol.

## VI. REFERENCES

None.

PROGRAM:	LUNG TRANSPLANTATION
AUTHOR(S):	K. CHAN, A. CHANG, J. BERRY-EDWARDS, L. HARCOURT
APPROVED BY:	JULES LIN, MD SURGICAL DIRECTOR, LUNG TRANSPLANTATION
	KEVIN CHAN, MD MEDICAL DIRECTOR, LUNG TRANSPLANTATION
HISTORY:	ISSUED SEPT. 14, 2015 (PREVIOUS VERSIONS: AUGUST 30, 2012; DEC. 6, 2006)
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FILE:	LUNG_ALL_SUBSTANCE_ABUSE_523.PDF (RELATED: LUNG_ALL_SUBSTANCE_ABUSE_CONTRACT_PER523.PDF)

## Tobacco, Alcohol, and Substance Abuse Contract



Name: \_\_\_\_\_

CPI#: \_\_\_\_\_

DOB: \_\_\_\_\_

The University of Michigan Lung Transplant Program requires that patients agree to abstain completely from tobacco and addictive illicit substances. Illicit substances include cannabis (marijuana), cocaine, heroin, and any controlled substance including medical marijuana even if it has been prescribed by a physician. As a lung transplant candidate, I also understand that use of tobacco in any form is strictly prohibited under this policy. This includes cigarettes, cigars, snuff, and chewing tobacco. Because of the harmful effects of nicotine, I understand that I cannot use any nicotine replacement via patch, gum, electronic cigarettes, vaporizers, etc. I also understand that I will be evaluated for abuse of all addictive substances on an ongoing basis. I understand that I may be expected to abstain completely from legal addictive substances, such as alcohol and prescribed (narcotic pain medications, benzodiazepines) or over the counter medication, as determined by the transplant team. I may be expected to have a period of time that I comply with this policy before being listed or activated on the transplant list. When requested, patients accepted for lung transplantation must agree to undergo random urine or blood testing for alcohol, addictive substances, and/or tobacco. Refusal to undergo such a test will be treated the same as a positive test: the patient will be removed from the transplant list.

Patients determined to be abusing alcohol must be certain they do not ingest alcohol of any kind, including cough medicines, over the counter medications containing alcohol, or "alcohol free" beer that contain small amounts of alcohol. If any patient being evaluated as a potential lung transplant recipient, or waiting for a transplant on the University of Michigan transplant list is found to have \*used and/or abused addictive substances, the patient will not be listed or will be removed from the list. A positive test for addictive substances or tobacco in the patient's blood or urine will be considered absolute evidence that the patient has violated the substance abuse policy. A conviction for driving while intoxicated or impaired will similarly be considered to be a violation of this policy.

I have read the above policy and agree to follow these conditions. Questions about the policy have been answered to my satisfaction, and I understand the meaning of the policy. I have been given a copy of this policy for future reference.

In addition, I agree to participate in substance abuse treatment if recommended by the Lung Transplant team. I will be provided a comprehensive list of treatment programs and I understand it is my responsibility to initiate treatment. I will provide the lung transplant social worker information regarding my treatment program, including name and phone number of my counselor.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

I have explained the above policy to the patient and answered any questions they asked.

\_\_\_\_\_  
(Social Worker signature) (phone #) Date \_\_\_\_\_

\* With respect to alcohol, this applies only to potential recipients who have previously been determined to be abusing alcohol.



# SPECIALTY PHARMACY SERVICES: TRANSPLANT

## What is Specialty/Transplant Pharmacy Services?

We specialize in providing outstanding customer service. As a comprehensive pharmacy program developed by the University of Michigan, the Specialty/Transplant Pharmacy ensures timely and continuous access to your critical transplant medications. We recognize the challenges transplant patients face with their medications and our experienced team is committed to supporting you with comprehensive care throughout the entire treatment process.

The Specialty/Transplant Pharmacy Services are unique from your neighborhood retail and mail-order pharmacies. We offer specialized mail-order distribution as well as clinical support, financial counseling and education services. In addition to all these services, our transplant patients have the advantage of enrolling in a pharmacy that is an extension of their specialized Michigan Medicine medical team. Using the Specialty/Transplant Pharmacy enhances patient care because we have access to complete medical records enabling accurate and efficient facilitation of your treatment plan. Our pharmacists are directly linked to your transplant care team, and we are dedicated to personally serving you.

Transplant patients can face significant challenges paying for their medications. Even with insurance coverage, some patients spend hundreds of dollars in medication co-pays each month. Due to the complexities of billing for specialty transplant medications, we offer financial counseling and insurance support services to help you navigate the details of your insurance, ensuring you are maximizing all available resources.

Patients can also face obstacles to acquiring their medication. Transplant medications are only needed by a small percentage of the population, so they are not always readily available at your local pharmacy. Specialty/Transplant Pharmacy specializes in transplant medications and is able to provide patients with commonly prescribed medications as well as those used less often. The Specialty/Transplant Pharmacy coordinates the efforts of professionals from across the medical center, including the University of Michigan Transplant Center and the Department of Pharmacy, to ensure prompt access to medications. Patients may also easily obtain answers about medication regimens and side effects.

## Why Should I Use Specialty/Transplant Pharmacy Services?

The Specialty/Transplant Pharmacy is an extension of your Michigan Medicine transplant patient care team. We offer:

- Personalized service for all of your medication needs from a dedicated pharmacy care team of pharmacists, certified technicians, financial coordinators, and billing specialists.



- Direct access to pharmacists who specialize in transplant medications.
- Pharmacists on call 24 hours a day, seven days a week.
- Your choice of telephone or e-mail refill reminders to ensure you don't run out of your medication.
- Financial and insurance coverage counseling focused on minimizing your out-of-pocket expense.
- The medications you need after transplant will be delivered to you before you leave the hospital.
- Delivery of medications in unmarked, temperature-appropriate shipping containers to your home, office, or alternative location within Michigan at no extra charge.
- Care kits for specialty transplant prescriptions that includes comprehensive educational materials and medical supplies to help you manage the daily challenges of your transplant medication regimen.

## Two Locations to Serve You

- East Ann Arbor Pharmacy
- Taubman Center Pharmacy

## CONTACT US

**Call 1-866-946-7695 for more info or to enroll with Michigan Medicine Specialty Pharmacy Services: Transplant**

4260 Plymouth Road, Ann Arbor / 866-946-7695 / [www.uofmhealth.org/specialty-pharmacy](http://www.uofmhealth.org/specialty-pharmacy)

## Authorization for Transplant Mailings

New federal regulations became effective in April 2003 which are intended to protect the uses of a patient's medical information. We need your written permission to send you general mailings from the University of Michigan Transplant Center. The mailings may include newsletters, information on upcoming events, articles of interest to the transplant community and development information. If you wish to receive our general mailings, please provide your consent below.

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I authorize the University of Michigan Transplant Center to add my name to its mailing list so I may receive Transplant Center newsletters and other mailings.

Patient Name: \_\_\_\_\_ CPI: \_\_\_\_\_

Patient Email Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Communicating With Your Donor Family

A transplant is a major surgical procedure and may take time before the person feels healthy again. It may take months and even years before someone is ready to send and /or receive correspondence from the donor family. It is normal to experience a wide range of feelings when communicating with or receiving information from a donor family. Those feelings may include excitement, guilt, anxiety or fear. We support you and whatever decision you make about communicating with your donor family. Some recipients may feel very happy to receive the correspondence from the donor family. Others may feel overwhelmed and find it difficult to express their thanks. Writing to your donor family does not mean you will get a response back. Some donor families may feel that writing about their loved one and their decision to donate helps them in their grieving process. Others choose not to write to the organ recipient.

If the donor family chooses to write they will send a letter to the Organ Procurement Organization, OPO. The OPO will then forward the letter to your transplant social worker. Your social worker will call you or see you in clinic before the letter is sent to you. Please know that often donor families include a photograph of the donor. Your social worker will talk with you about whether a photo is included. It is common for recipients to imagine what their donor looked like, how old they were, and how they died. Often the reality is different from what is imagined. Your transplant social worker is available to talk with you about your feelings regarding this sometimes emotional experience.

When the transplant recipient is a child, these issues can become more challenging for the child, parents/guardians and siblings. The information regarding the donor may be more difficult to process if the donor was also a child. It may impact each member of the family differently. Children have unique coping and adjustment needs. This process of learning about their organ donor may impact their behavior, sleep, school performance, and other social needs depending on their age. Your social worker can talk with you to make sure that you help your child learn about this information in developmentally appropriate ways. They can also provide the parents/guardians with adequate support about the process.

## Writing to Your Donor Family

### **Have you ever wondered how you could thank the family that made your transplant possible?**

The decision to write to your donor family is a personal choice. It may help you to know that donor families consistently express gratitude by hearing from their loved one's recipients. Some recipients will choose to write to their donor family, and others will not. There is no time limit to write to your donor family, but it requires thoughtful consideration. Your transplant social worker is available to talk to you if you are having difficulty with your feelings. If you do not wish to write at this time, feel free to wait or have a family member write on your behalf. You may also consider sending a Thank You or Thinking of You card. Writing to your donor family does not mean you will get a response back as some donor families never write.

### **Suggestions:**

- Write about yourself – your hobbies, family, friends, interests, etc. Please consider carefully about including religious comments in your letter, as the religious background of the donor family is unknown.
- Write about your personal transplant experience – how long you waited, how the transplant affected your life.
- Thank the family for their gift of life and express your sympathy to them for their loss.
- Sign only your first name, and do not include any identifying information.

### **Sending your correspondence:**

- Place your card or letter in an envelope, unsealed.
- On a separate piece of paper write your full name, date of transplant and organ you received.
- Place all in an envelope and mail to: Gift of Life Michigan  
3861 Research Park Drive  
Ann Arbor, MI 48108

As time passes and if the donor family and recipient both agree, they can correspond directly and/or meet in person. These arrangements are made through Gift of Life and both parties must sign a release of information form.

Please contact Gift of Life Michigan if you have any questions at **(734) 922-1028**.



## Notes

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