RESOURCES

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


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.

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, 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

- **National Foundation for Transplants**
  5350 Poplar Avenue, Suite 850
  Memphis, Tennessee 38119
  (800) 489-3863 toll-free
  (901) 684-1128 fax
  www.transplants.org
Transplant-Related Websites

• University of Michigan Transplant Center
  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
  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
  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
  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
  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
  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: 734-615-5334 or avanzee@med.umich.edu or Stephanie Zaientz, LMSW: 734-232-5001 or szaientz@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; Jacque 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
**Local Michigan Resources:**

**Gift of Life Michigan**
3861 Research Park Dr.
Ann Arbor, MI 48108
800-482-4881
www.giftoflifemichigan.org

**Lions of Michigan Service Foundation**
5730 Executive Drive
Lansing, MI 48911
517-887-6640
Email: info@lmsf.net
www.lmsf.net

**Michigan Rehabilitation Services**
201 N. Washington Sq., 4th Floor
Lansing, MI 48933
517-373-3390
1-800-605-6722

**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. 1-800-285-WORKS www.mitalent.org

**Second Chance at Life**
PO Box 85087
Westland, Michigan 48185
734-748-9690
www.secondchanceatlife.org
National Resources:

American Association of Sex Educators, Counselors, and Therapists (AASECT)
To find a local sex therapist, visit www.aasect.org.

American Diabetes Association
300 Galleria Officentre, Suite 111
Southfield, MI 48034
248-433-3830 or 1-800-342-2383

American Kidney Fund
11921 Rockville Pike, Suite 300
Rockville, MD 20852
1-800-638-8299
www.kidneyfund.org
Email: helpline@kidneyfund.org

American Lung Association
55 W. Wacker Dr., Suite 1150
Chicago, IL 60601
312-801-7630
1-800-LUNGUSA
www.lung.org

American Organ Transplant Association
P.O. Box 418
Stilwell, KS 66085
713-344-2402
www.aotaonline.org

The Healthwell Foundation
PO Box 4133
Gaithersburg, MD 20885
800-675-8416
www.healthwellfoundation.org

Second Wind Lung Transplant Association, Inc.
Toll Free Help Line: (888) 855-9463
www.2ndwind.org
Transplant Recipients International Organization
1-800-TRIO-386
www.trioweb.org

United Network for Organ Sharing (UNOS)
P.O. Box 2484
Richmond, VA 23218
1-888-894-6361
www.unos.org

Disease Specific Websites:

Alpha -1 Foundation
www.alpha1.org

Coalition for Pulmonary Fibrosis
www.coalitionforpf.org

Cystic Fibrosis Foundation
www.cff.org

Efforts (Emphysema Foundation For Our Right To Survive)
www.emphysema.net

Michigan Pulmonary Disease Community Inc.
www.mpdci.org

Pulmonary Hypertension Association
www.phassociation.org

Quest for Breath
questforbreath@umich.edu
866-860-0026
Pulmonary Fibrosis Support
www.questforbreath.org

Sarcoid Networking Association
www.sarcoidosisnetwork.org

The LAM foundation
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 .............................................................................................................................................................................................................

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

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

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

.......................................................................................................... Date
Witness signature

.......................................................................................................... Date
Witness signature

PRINT Witness’s name

..........................................................................................................
Witness’s telephone number

.......................................................... Date
Witness signature

.......................................................... Date
Witness signature

PRINT Witness’s name

..........................................................................................................
Witness’s telephone number

.......................................................... Date
Witness signature

.......................................................... Date
Witness signature

PRINT Witness’s name

..........................................................................................................
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
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

MLABS BLOOD DRAWING LOCATIONS

WEST ANN ARBOR HEALTH CENTER
380 Parkland Plaza, Suite 130
Ph: 734.232.9720  Fax: 734.232.9772
Mon-Thu 7am - 7pm
Fri 7am - 5pm
Sat 8am - Noon

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

BRIARWOOD HEALTH CENTERS
Building 4
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 - 1pm
(Closed 2nd Wednesday of each month 8am - 1pm)

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

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Resources | 15
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 ______________________________________

Name: ______________________________ Phone Number: __________________ Relationship: ______________________
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.

____________________________________________ Date _____________ _____

(Social Worker signature)  (phone #)

* 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: JULIE LIN, M.D. KEVIN CHAN, M.D.
SURGICAL DIRECTOR, LUNG TRANSPLANTATION MEDICAL DIRECTOR, LUNG TRANSPLANTATION
KEYWORDS: LUNG TRANSPLANTATION, POLICIES, SUBSTANCE ABUSE, ADDICTION, CHEMICAL DEPENDENCE, ALCOHOL, SMOKING, NICOTINE, TREATMENT, SOBERTY, PROCEDURES, GUIDELINES
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.

_________________________________________ Date________________

(Social Worker signature) (phone #)

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

- 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
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.

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.