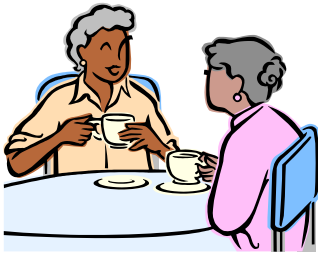


# Minnesota Advance Health Care Directive

NAME \_\_\_\_\_

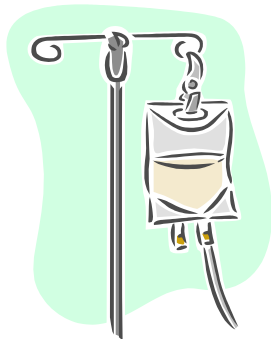
This form lets you have a say about how you want to be treated if you get very sick.

✱ This form has 3 parts. It lets you:



## Part 1: Choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.



## Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.



## Part 3: Sign the form.

It must be signed before it can be used.

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You can fill out Part 1, Part 2, or both. Fill out only the part(s) you want. Always sign the form in Part 3.

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Go to the next page



If you only want a health care agent go to Part 1 on page 3.

If you only want to make your own health care choices go to Part 2 on page 6.

If you want both then fill out Part 1 and Part 2.

Always sign the form in Part 3 on page 9.

☀ **What if I have questions about the form?**

- Bring it to your doctors, nurses, hospital chaplains, social workers, family or friends to answer your questions.

☀ **What if I want to make health care choices that are not on this form?**

- Write your choices on a piece of paper
- Keep the paper with this form
- Share your choices with those who care for you

☀ **What do I do with the form after I fill it out?**

Share the form with those who care for you:

- Doctors
- Nurses
- Social Workers
- Health care agents
- Family
- Friends

Make copies, then give a copy to your:

- Family doctor
- Local hospital
- Health care agent(s)
- Family

Keep this form at home with your other important papers.

☀ **What if I change my mind?**

- Change the form and make new copies. Tear up old copies.
- Tell those that care for you about your changes.



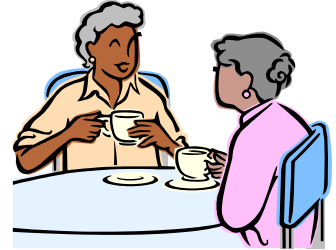
# **PART 1** Choose your health care agent

The person who can make medical decisions for you if you are too sick to make them yourself.

## ✿ Whom should I choose to be my health care agent?

A family member or friend who:

- Is at least 18 years old
- Knows you well
- Can be there for you when you need them
- You trust to do what is best for you
- Can tell your doctors about the decisions you made on this form

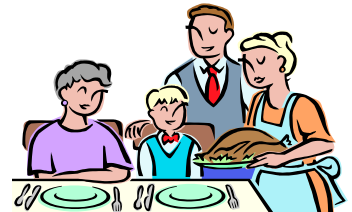


Your agent **cannot** be your doctor or someone who works at your hospital or clinic, unless they are a family member.

## ✿ What will happen if I do not choose a health care agent?

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

If you want your agent to be someone other than family, you must write his or her name on this form.



## ✿ What kind of decisions can my health care agent make?

Agree to, say no to, change, stop, choose, or be able to:

- Doctors, nurses, social workers
- Hospitals or clinics
- Medications or tests
- What happens to your body & organs after you die
- Obtain copies of your medical record and allow others to see them.



## Other decisions your agent can make:

### ☀ Life support treatments – medical care to try to help you live longer

#### ◆ CPR or cardiopulmonary resuscitation

Cardio = heart      pulmonary = lungs      resuscitation = to bring back

This may involve:

- pressing hard on your chest to keep your blood pumping
- electrical shocks to jump start your heart
- medicines in your veins



#### ◆ Breathing machine or ventilator

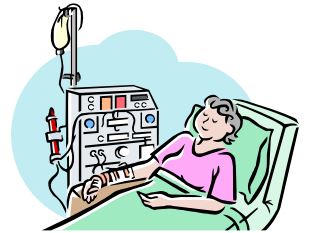
The machine pumps air into your lungs and breathes for you.  
You are not able to talk when you are on the machine.

#### ◆ Dialysis

A machine that cleans your blood if your kidneys stop working.

#### ◆ Feeding Tube

A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.



#### ◆ Blood transfusions

To put blood in your veins.

#### ◆ Surgery

#### ◆ Medicines

### ☀ End of life care – If you might die soon your health care agent can:

- Call in a spiritual leader
- Decide if you die at home or in the hospital



**Show your health care agent this form.  
Tell your agent what kind of medical care you want.**



## Part 1: YOUR HEALTH CARE AGENT

☛ I want this person to help make my medical decisions:

|                   |                   |              |          |
|-------------------|-------------------|--------------|----------|
| First name        | Last name         | Relationship |          |
| Street address    | City              | State        | Zip code |
| ( )               | ( )               |              |          |
| Home phone number | Work phone number |              |          |

☛ If the first person cannot do it, then I want this person to help make my medical decisions:

|                   |                   |              |          |
|-------------------|-------------------|--------------|----------|
| First name        | Last name         | Relationship |          |
| Street address    | City              | State        | Zip code |
| ( )               | ( )               |              |          |
| Home phone number | Work phone number |              |          |

☛ Put an X next to the sentence(s) you agree with:

- My health care agent can make decisions for me **now**.
- My health care agent will make decisions for me after I cannot make my own decisions.

**To make your own health care choices go to part 2 on the next page.**

**To sign this form go to part 3 on page 9.**



## **PART 2** Make your own health care choices

Write down your choices so those who care for you will not have to guess.

☀ **Think about what makes your life worth living.**  
Put an X next to all the sentences you agree with.

- My life is only worth living if I can:
  - talk to family or friends
  - feed, bathe, or take care of myself
  - be free from pain
  - live without being hooked up to machines
  - my life is always worth living no matter how sick I am

☀ **If I am dying, it is important for me to:**  
 be in my home     not be in my home     have hospice care

☀ **Is religion or spirituality important to you?**  
 yes     no

☀ **What should others know about your religion or spirituality? (If you wish, you may name your religion, the church you attend, Sacraments you want, etc.)**

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If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.



## Part 2: MAKE YOUR OWN HEALTH CARE CHOICES

**Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or certain kinds of medicines.**

**Put an X next to the sentence you most agree with.  
Please read this whole page before you make your choices.**

☼ **If I am so sick that I may die soon:**

- Try all life support treatments that my doctors think might help. If the treatments **do not work**, I want to **stay** on life support machines even if there is little hope of getting better.
- Try all life support treatments that my doctors think might help. If the treatments **do not work** and there is little hope of getting better, I **do not want to stay** on life support machines or receive CPR. Continue medications that keep me comfortable.
- Try all life support treatments that my doctors think might help **but not** these treatments. Mark what you **do not want**.
  - CPR
  - Dialysis
  - Breathing machine
  - Other treatments \_\_\_\_\_
  - Feeding tube
  - Blood transfusion
- I **do not want** any life support treatments. Continue medications that keep me comfortable.
- I want my **health care agent** to decide for me.



**Your doctors may ask about organ and tissue donation, autopsy, and what happens to your body after you die.  
Please tell us your wishes.**

Put an X next to the sentences you most agree with

**\* Donating (giving) your organs or tissue (skin, bone, eyes) can help save or improve lives.**

I want to donate my organs and/or tissue.

Which organs or tissue do you want to donate?

Any organs or tissue

Only \_\_\_\_\_

I **do not** want to donate my organs or tissue.

I want my **health care agent** to decide.

**\* An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.**

I want an autopsy.

I do not want an autopsy.

I may want an autopsy if there are questions about my death.

I want my health care agent to decide.

**\* Put an X next to the sentence saying what you want to have happen to your body after you die.**

I want a traditional burial.

I want to be cremated.

I want my health care agent to decide.

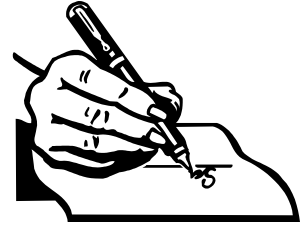
**Go to Part 3 on the next page to sign this form**





## Part 3: WITNESSES SIGN THE FORM

**Have your witnesses sign their names and write the date**



**\* Witness #1**

\_\_\_\_\_/\_\_\_\_\_  
Witness sign name Date

\_\_\_\_\_  
Witness print first name and last name

\_\_\_\_\_  
Address City State Zip code

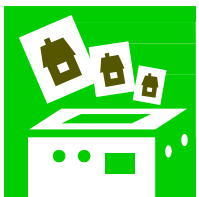
**\* Witness #2**

\_\_\_\_\_/\_\_\_\_\_  
Witness sign name Date

\_\_\_\_\_  
Witness print first name and last name

\_\_\_\_\_  
Address City State Zip code

**You are now done with this form.**



- Make a copy of this form for your doctors, local hospital, health care agents and your family.
- Talk with them about your choices.
- Keep this form at home with your important papers.



Form developed by Renee Sudore, University of California, San Francisco: obtain at [www.iha4health.org](http://www.iha4health.org).  
Adapted for State of Minnesota at St. Gabriel's Hospital, Little Falls, MN, 320-632-5441  
NFHealth Care Directive Form.doc-mlk 10/06



# NOTARY PUBLIC

- Take this form to a notary public ONLY If two witnesses have not signed this form on page 10.
- Bring photo I.D. (driver's license, passport, etc.)



## CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC STATE OF MINNESOTA

County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me

\_\_\_\_\_  
(print name of notary public)

personally appeared \_\_\_\_\_  
(print name of person completing this form)

and has proved to me on the basis of satisfactory evidence, to be the person whose name is indicated on this advance health care directive, and has stated that he or she did complete this form. I declare under penalty of perjury, that the person, whose name is indicated in the advance health care directive, appears to be of sound mind and is under no duress, fraud, or undue influence.

NOTARY SEAL

\_\_\_\_\_  
(Signature of Notary)

\_\_\_\_\_  
(Date)

## You are now done with this form.



- Make a copy of this form for your doctors, local hospital, health care agents and your family.
- Talk with them about your choices.
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