

HEALTH CARE DIRECTIVE

(For use in the State of Minnesota)

I, _____, understand this document allows me to do ONE OR BOTH of
(Name of principal) of the following:

PART I:

Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on:

- a) Instructions I provide in Part II of this document, if any, or
- b) The wishes I have made known to him or her in some other way.

If I have not made my health care wishes known, my agent must act in my best interest.

AND/OR

PART II:

Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care, and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT

Below is named the person who I want to make health care decisions for me if I am unable to decide or speak for myself. This person is at least 18 years or older, knows me well, and is able to make difficult decisions. My agent (alternate agent) is not my health care provider or the operator of a health, residential, or community care facility serving me. My agent (alternate agent) is not an employee of my health care provider unless my agent is an employee and also a member of my immediate family.

(I know I can change my agent or alternate agent at any time. I also know I do not have to appoint an agent or an alternate agent.)

[NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.]

When I am unable to decide or speak for myself, I trust and appoint _____ to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me: _____
Telephone number of my health care agent: _____
Address of my health care agent: _____

APPOINTMENT OF ALTERNATE HEALTH CARE AGENT (OPTIONAL):

If my health care agent is not reasonably available, is divorced or legally separated from me or this person has died, I trust and appoint _____ to be my health care agent instead.

Relationship of my alternate health care agent to me: _____
Telephone number of my alternate health care agent: _____
Address of my alternate health care agent: _____

My Health Care Agent is Automatically Given the Powers Listed Below in (a) through (g).

(I know I can change these choices at any time by writing a new directive and destroying all old copies.)

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

- (a) Make choices for me about my medical care or services, like tests, medications, and surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.
- (b) Make decisions about intrusive mental health therapies and medications.
- (c) Interpret instructions I have given in this form or elsewhere in order to carry out my wishes and values.
- (d) Arrange for hospital, hospice, or long term care for me.
- (e) Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive keeping in mind my wishes as stated in Part II.
- (f) See and approve release of my medical records. If I need to sign my name to get these records, my Health Care Agent can sign for me.
- (g) In the event I am pregnant, decide to continue my pregnancy to delivery based on my values, preferences or instructions.

If I **DO NOT** want my health care agent to have a power listed above in (a) through (g), **OR** if I want to **LIMIT** any power in (a) through (g), I **MUST** say that here: _____

My health care agent is **NOT** automatically given the powers listed below in (1) and (2). If I **WANT** my agent to have any of the powers in (1) and (2), I must **INITIAL** the line in front of the power; then my agent **WILL HAVE** that power.

- _____ (1) To decide whether to donate my organs when I die.
- _____ (2) To decide what will happen with my body when I die (burial, cremation).

I have / have not (circle one) stated my wishes about (1) and (2) in Part II.

Additional Comments (if any): _____

PART II: HEALTH CARE INSTRUCTIONS

[NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional, but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II, if you wish to make a valid health care directive.]

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

These are My Beliefs and Values About My Health Care

(I know I can change these choices or leave any of them blank.)

Life-support treatment means medical procedures, devices or medications to keep me alive. These treatments may prolong the dying process. Life-support treatment includes: medical devices put in me to help me breathe (respirator); food and water supplied artificially (tube feeding); attempts to re-start a stopped heart (CPR); major surgery; blood transfusions; dialysis; and antibiotics.

I have these views about my health care in these situations:

1. **If I am in a coma:**

If my doctor and another health care professional have allowed a reasonable amount of time to assess for the possibility of my recovery and both decide that I am in a coma from which I am not expected to wake up or recover and have determined that life-support treatment would only postpone the moment of my death

(choose one of the following):

I want to have life-support treatment.

I do not want life-support treatment. If it has been started, I want it stopped.

2. **If I have permanent or severe brain damage:**

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example: I can not speak or understand) and I am not expected to recover, and life-support treatment would only postpone the moment of my death **(choose one of the following):**

I want to have life-support treatment.

I do not want life-support treatment. If it has been started, I want it stopped.

3. **If I am in another terminal condition (end-stage disease, i.e., Alzheimer=s, cancer, heart, lung, kidney) or advanced age (choose one of the following):**

Yes, I do want **(circle all that apply):** dialysis, antibiotics, CPR, respirator, tube feeding, blood transfusions, chemotherapy, radiation, other: _____

No, I do not want life-support treatment for any of these conditions. I believe that the costs and burdens of life-support treatment would not be worth the benefits to me and would only delay the moment of my death.

4. **If I have a reasonable chance of recovery and was temporarily unable to decide or speak for myself, I would want all treatments reasonably calculated to promote improvement in my condition.**

Yes No

5. **My wishes about pain control:**

I want to be given enough medicine to relieve my pain even if that means that I will be drowsy or sleep more than I would otherwise. Yes No

Comments: _____

6. **My wishes about donating organs, tissue, or other body parts (*Check the box that applies to you*):**

Yes, I **DO** wish to donate organs, tissue, or other body parts when I die. Limitations (if any) include: _____

No, I **DO NOT** wish to donate organs, tissue, or other body parts when I die.

The Following Are My Spiritual Beliefs and Wishes About Comfort Care.

These wishes are not added legal duties for my doctors or other health care providers.

(I understand that completing this page is optional. Leaving it blank does not affect the validity of this document.)

My spiritual or religious beliefs:

- Yes No I believe in God/Yahweh/Higher Power.
- Yes No I want my pastor/priest/rabbi notified that I am ill.

I want others to know the following about my spiritual/religious beliefs:

My wishes about comfort care:

(Please check boxes that you agree with.)

- I want my position to be changed occasionally.
- I want friends/caregivers to check on me so I don't feel alone.
- I want to be touched (by holding my hand, a gentle back rub or massage).
- I want to have a prayer said with me/for me each day.
- I want brief readings from a good book, prayer book, bible, or newspaper.
- I want my worshiping community to know that I am sick and to pray for me.
- I want to die at home with hospice care, if possible, not in a hospital or other facility.

These are the things I want my loved ones to know.

- I want family members and loved ones to know that I love them.
- I want forgiveness for the times I have hurt my family, friends and others.
- I want family and friends to know that I forgive them for ways they may have hurt me in my life.

When I die, I want:

traditional burial at (cemetery location): _____

cremation with cremains buried at: _____

I want (name funeral home and city) _____
to make funeral arrangements for me.

I do/do not (circle one) want a funeral or memorial service. I want the service to be held at (location):

_____ and to include the following (*list music, songs, readings or other specific requests that you have*):

I want to be remembered as follows:

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a Notary Public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

Dated: _____

 My Signature (principal listed at top of page 1)

Date of Birth: _____

Address: _____

If I cannot sign my name, I can ask someone to sign this document for me: _____

Signature of the person who I asked to sign this document for me: _____

Printed name of the person who I asked to sign this document for me: _____

OPTION 1: NOTARY PUBLIC

STATE OF MINNESOTA

COUNTY OF _____

In my presence on _____ (date), _____ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

(Notary Stamp)

Signature of Notary

REMINDER: *Keep document with your personal papers in a safe place (not in a bank safe deposit box). Give signed copies to your doctors, family, close friends, health care agent and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician=s office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.*

OPTION 2: TWO WITNESSES

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

The agent or alternate agent named in this document (Part I) may not act as witness. (A family member not named as the agent or alternate agent may act as a witness.)

WITNESS ONE:

- (I) In my presence on _____ (date), _____
(Insert name of principal listed at top of page 1)
acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
- (II) I am at least 18 years of age.
- (III) I am not named as a health care agent or an alternate health care agent in this document.
- (IV) If I am a health care provider or an employee of a health care provider giving direct care to the person completing this directive, I must initial this box: []

I certify that the information in (I) through (IV) is true and correct.

Signature of Witness One

Date of Birth: _____

Address: _____

WITNESS TWO:

- (I) In my presence on _____ (date), _____
(Insert name of principal listed at top of page 1)
acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
- (II) I am at least 18 years of age.
- (III) I am not named as a health care agent or an alternate health care agent in this document.
- (IV) If I am a health care provider or an employee of a health care provider giving direct care to the person completing this directive, I must initial this box: []

I certify that the information in (I) through (IV) is true and correct.

Signature of Witness Two

Date of Birth: _____

Address: _____

REMINDER: *Keep document with your personal papers in a safe place (not in a bank safe deposit box). Give signed copies to your doctors, family, close friends, health care agent and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.*