Health Care Directive

Introduction

I have completed this health care directive with much thought. This document gives my treatment choices and preferences and may appoint one or more Health Care Agent(s) to make health care decisions for me if I do not have decision-making capacity. Decision-making capacity means the ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.

If I do not have decision-making capacity for a particular health care decision or group of decisions, my Health Care Agent(s), if named, is/are able to make those health care decisions for me, including the decision to refuse treatments. I know that I can use this health care directive to give my treatment choices and preferences, or I can name and agent, or I can do both. I do not have to do both for this to be a true expression of my wishes.

Any advance care directive document created before this is no longer legal or valid.

This Health Care Directive is for:

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

NOTE: *Please complete as much of this directive as you are comfortable with. Answer any questions that you feel will give your Health Care Agent(s), support people, others close to you, and/or health care team the best guidance about your health care wishes, goals, and values. You may leave questions blank or write "NA" if you choose not to answer them.*

This document does not apply to intrusive mental health treatments, defined as electroconvulsive therapy or neuroleptic medications. Please speak with your provider to address these specific concerns.

Part 1: My Primary Health Care Agent

If my health care team determines that I do not have decision-making capacity for a health care decision or group of decisions, I appoint the following person to make and communicate health care decisions for me.

Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

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My **Alternate** Health Care Agent is (optional):

Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

I understand that my Health Care Agent(s), primary or alternate, cannot be a health care provider or employee of a health care provider giving direct care to me, unless I am related to the that person by blood or marriage, registered domestic partnership, adoption, or provide a clear reason why I want that person to serve as my agent, noted here:

1. My Health Care Agent can: (Please Initial)

_____ Follow my health care instructions in this document.

_____ Follow any instructions I have given to my agent if I have not provided guidance in a particular situation.

_____ Make decisions in my best interest if my wishes are not known.

_____ Make decisions for me based on the input from my medical providers and/or other medical professionals.

2. Powers of my Health Care Agent:

My Health Care agent automatically has the following powers when I am unable to make and communicate a health care decision or decisions for myself unless I choose to limit these powers:

- Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, taking out or not putting in tube feedings, and any other decisions related to treatments. If treatment has already begun, my agent can continue or stop it.
- Interpret any instruction in this document based only agent's understanding of my wishes, values, and beliefs.
- Review and release my medical records and personal files as needed for my health care, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Minnesota Health Records Act.

Comments on or limits to the above: _____

_____

_____

3. Additional powers of My Health Care Agent:

My **initials below** indicate I also authorize my Health Care Agent to:

_____ If my agent is my spouse or domestic partner, to continue as my Health Care Agent even if our marriage or domestic partnership is legally ending or has ended.

_____ In the event I am pregnant, to decide whether to continue my pregnancy based upon my agent's understanding of my values, preferences, beliefs, and/or instructions.

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Part 2: My Hopes and Wishes (each question optional):

1. Health Care Agent(s) and health care team shall know my thoughts and feelings about how health care decisions should be made for me, based on how they are usually made in my community, family, cultural group, faith tradition, tribe, or another affiliation important to me:

2. What I value most in my day-to-day life and what I would not want to live without is/are:

3. If I am ill and/or nearing death, it would support me to receive the following ritual, prayers, music, companionship, etc.:

4. My beliefs about when I would feel that my life had reached its end and when I would feel that the burdens of continued treatment(s) would outweigh the benefits are:

5. My thoughts about what it would mean to live well at the end of life are:

5. My thoughts and feelings about how and where I would like to die and what a good death would look like are:

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7. Religious/Spiritual/Ethical Belief Affiliation:

I am of the _____ religion/spirituality/ethical belief system.
I am a member of and/or attend services/meetings at:

_____

The address/city/state/zip of my community is:

_____

Contact name and phone number for my community is: _____

I authorize contact to the above in the event of a serious illness, hospitalization, or death. **Circle one:** YES NO

Part 3: My Health Care Instructions

If I can no longer make or communicate a particular health care decision, my decision maker(s) should:

a. Discuss, when possible, the range of reasonable treatment options with my health care team.
b. Consider the team's recommended options including the foreseeable benefits, burdens, and risks.
c. Make decisions for me based on their knowledge of my wishes and/or best interests.

1. My current Health Condition(s) and Treatment Choices, choose only one:

_____ I do not currently have any significant health concerns, diagnoses, health conditions, family history, etc.
_____ I currently have the following health concerns, diagnoses, health conditions, family history, etc

_____

_____

I have made the following choices about treatments for these specific concerns:

_____

_____

2. Cardiopulmonary Resuscitation (CPR): An Emergency Intervention

CPR is a treatment used to attempt to restore heart rhythm and breathing when they stop. CPR may include chest compressions, medications, electrical shocks, a breathing tube, and hospitalization. CPR does not work as well for those who have long-term diseases, impaired functioning, or both. It can result in serious injuries.

If my heart or breathing stops, **choose only one:**

_____ I want CPR attempted.
_____ I want CPR **attempted unless** my medical team does not recommend it.
_____ I want CPR **attempted only** if I have a reasonable hope of returning to an acceptable quality of life.
_____ I want to **allow a natural death**. **I do not want CPR attempted** if my heart or breathing stops. If I choose this option, I should talk to my provider about a Provider Order for Life Sustaining Treatment (POLST) form. For more information see: https://www.mnmed.org/POLST

3. Treatments That Will or May Prolong My Life

If I have a serious illness or injury, including a brain injury where I no longer recognize myself or others, and require life-sustaining interventions to keep me alive, I want my decision-makers to know:

_____

_____

_____

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(Treatments continued) Choose only one:

_____ I would want to **stop or withhold all treatment(s) to extend my life** offered by my care team. The only additional treatment(s) I would accept would be those focused on my comfort.

_____ I would **accept all treatment(s) to extend my life** offered by my health care team only for as long as my health care team believes they are helping and not harming me.

_____ I would **accept any treatment(s)** to extend my life.

_____ I want **my decision-makers to decide** based on their knowledge of my values and beliefs.

Pain and comfort:

NOTE: With any of the choices below, I understand that:

a. It is standard practice for health care teams to alleviate pain and suffering to the fullest extent possible.
b. Sometimes adequately controlling my pain means that I can no longer think clearly or be conscious.
c. My wishes for symptom management, for example the treatment of pain, will be considered by my team.
d. I will have access to food and liquids by mouth as long as I am able to safely swallow and digest food.

My Preferences about pain and comfort treatments are as follows, **choose only one:**

_____ I want to **receive all treatments** that my health care team recommends to keep me comfortable.

_____ I **request the following limitations** on pain and comfort treatments. For example, "I do not want so much pain medication that it limits my ability to interact with others; or I would like to receive hospice care if appropriate."

_____

_____

_____

Organ Donation & Care of My Body After Death:

Choose none, one, or both, if applicable:

_____ I authorize my Health Care Agent to decide how to care for my body after death.

_____ I authorize my Health Care Agent to decide about organ donation.

By choosing the above, I understand my Health Care Agent, has the power to start, continue, and/or stop treatments or interventions needed to maintain my organs, tissues, and/or eyes until donation has been completed.

a. My Preferences about Anatomical (Organ) Donation:

Organs, Tissues, & Eye Donation, **choose only one:**

_____ I would like to **donate any part of my body** that my health care team believes could benefit others.

_____ I would like to **donate any part of my body except:** _____

_____ I **do not want to donate** any parts of my body.

b. Full Body Donation Only If Applicable:

I have already made prior arrangements for my full body to be donated after my death to the following organization: _____

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Part 4: Legal Authority

Under Minnesota law, 2 witnesses **OR** a notary public must verify your signature and the date. Your witnesses and notary public cannot be named as your primary or alternate Health Care Agent. **Wait to sign this form until you are in the presence of your two witnesses or the notary public so they can witness the signatures.**

I have made this document willingly, I am thinking clearly, and I affirm this document states my wishes about future health care decisions:

Signature: _____ Date: _____

If I cannot sign my own name, I ask the following person to sign for me:

_____ _____

(Printed Name) **(Signature of person asked to sign)**

Statement of Witnesses:

This document was signed or verified in my presence. I certify that I am at least 18 years of age, and I am not appointed as a primary or alternate Health Care Agent in this document.

If I am a health care provider or an employee of a health care provider giving direct care to the person listed above, I must initial here_____. Only one witness can be a provider or an employee of the provider giving direct care on the date this document is signed.

Witness 1:

Printed Name: _____

Signature: _____

Date: _____

Address: _____

City/State: _____

Witness 2:

Printed Name: _____

Signature: _____

Date: _____

Address: _____

City/State: _____

OR affix notary stamp below:

Notary Public:

In the State of Minnesota, County of _____ in my presence on _____ (date).

_____ (name) acknowledged their signature on this document or that they authorized the person signing this document to sign on their behalf. I am not named as a primary or alternate Health Care Agent document.

Notary Stamp:

Notary Signature: _____

Notary Commission Expires (date): _____

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Part 4: Any Additional Information Not Already Covered (optional):

I would like to use this space to add any information not already addressed and/or to share additional thoughts:

Part 6: Recommended Next Steps

Now that I have completed my Health Care Directive, I should:

☐ Talk to my loved ones, friends, elders, trusted individuals, and other important people in my life and let them know who my Health Care Agent(s) is/are and what my health care wishes are.

☐ Give copies of this completed document to my Health Care Agent(s) and to my medical provider(s) to be scanned into my electronic medical record.

- I understand this document is not shared between healthcare systems and I will give separate copies to each system where I receive care.

☐ Keep a copy of my Health Care Directive where it can easily be found.

☐ Review my health care wishes whenever any of the "Five D's" occur:

i. Doctor - when I switch medical providers or have a checkup.
ii. Death - whenever I experience the death of someone close to me.
iii. Divorce - when I experience a divorce or other major family change.
iv. Diagnosis - when I am diagnosed with a serious health condition.
v. Decline - when I experience a significant decline or deterioration of an existing health condition, especially when I am unable to live on my own.

If my wishes change, I will fill out a new Health Care Directive. I will give copies of the new document to everyone who has copies of my previous Health Care Directive. I will tell them to destroy the previous version.

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Wishes for Health Care: Short Form[1]
Minnesota Health Care Directive[2]

Full Name: _____ Date of Birth: _____

1. **I appoint the following person to serve as my primary health care agent.** This person will make health care decisions for me if I cannot communicate or make these decisions myself:

   Name: _____ Relationship: _____

   Cell phone: _____ Other phone: _____

   (Optional): **I appoint this person as my alternate health care agent** in the event my primary health care agent is not available:

   Name: _____ Relationship: _____

   Cell phone: _____ Other phone: _____

2. *(Optional)*: **I give the following instructions about my health care** (my values and beliefs, what I do and do not want, views about specific medical treatments or situations): *If you need more space, continue on other side.*

   _____

   _____

   _____

Signature: _____ Date: _____

Notary Public in the State of Minnesota

County of _____ Notary Seal

In my presence _____ (date), _____ (name) acknowledged his or her signature on this document, or acknowledged that he or she authorized the person signing this document to sign on his or her behalf.

Signature of Notary _____

My commission expires _____ (date)

OR Statement of two (2) Witnesses

Witness 1 _____ Witness 2 _____

Date signed _____ Date signed _____

Print Name _____ Print Name _____

(Witnesses must be 18 years of age or older and cannot be your primary or alternate health care agent. One witness cannot be your health care provider or an employee of your health care provider.)

1 A long form is available if you wish to more fully describe your health care wishes.
2 This document will not apply to any intrusive mental health treatments (electroconvulsive therapy or neuroleptic medications).

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Do I have to complete this Health Care Directive?

No. You may complete it today or at a later date, or you can decline to complete it. However, completing this form will help make sure you get the care you want. Putting your choices in writing helps loved ones know if they're doing what you would want.

What information am I being asked for?

Question 1: This question is about your health care "agent." Your agent is someone you choose to speak and make health care decisions for you if you cannot. Consider naming a family member or friend who knows you well and understands your values. Showing your agent this document and talking about it with him or her is important. Make extra copies to share with your health care agent, health care providers, and other important people in your life.

Question 2 *(Optional)*: This question is about health care and other wishes you may have. You may be as specific or general as you like. You may include:

- Your goals, values, and preferences about medical care
- The types of medical treatment you would want or not want
- How you want your agent or agents to decide
- Where you would like to receive care (such as at home or a hospital)
- Whether or not you would like to donate your organs, tissues, and eyes

Notary Public or Witnesses

A notary public or 2 witnesses must verify your signature on this Health Care Directive. The witnesses must be 18 years of age or older, and cannot be your primary or alternate health care agent. At least one witness cannot be your health care provider or an employee of your health care provider.

What should I do after I complete this Health Care Directive?

Tell the people you named as your primary and alternate health care agents, if you have not already done so. Make sure they feel able to do this important job for you in the future. Give a copy of your health care directive to your health care provider. Keep additional copies for your records and to share with your health care agents and family or others as you wish.

Who can I talk with if I have questions?

Your health care provider can answer your questions or concerns. He or she may refer you to an Advance Care Planning Facilitator for help.

Use the space below to continue your wishes about your health care (question 2 from front page), or to add comments.