Minnesota Health Care Directive
Long Form

My Healthcare Directive

Name _____ Date of Birth:_____

Home Phone: _____ Cell Phone:_____

Introduction

I completed this Health Care Directive to share my wishes for medical care. It explains the treatments I want or do not want, and names someone to make decisions for me if I am unable.

"Decision-making capacity" means being able to understand the benefits, risks, and options for care, and being able to communicate a decision. This document doesn't cover certain mental health treatments, like shock therapy or strong mood-stabilizing medications.

Any previous versions of my Health Care Directive are no longer valid.

Part 1: My Health Care Agent

If I am unable to make my own medical decisions, I want the person listed below to speak for me. I understand my Health Care Agent cannot be my doctor, nurse, or anyone who provides my direct medical care unless they are a family member.

Primary Health Care Agent

Name: _____ Relationship:_____

Home Phone: _____ Cell Phone:_____

Alternate Health Care Agent (optional)

Name: _____ Relationship:_____

Home Phone: _____ Cell Phone:_____

Why I chose the people listed above:

_____

_____

_____

What My Health Care Agent Can Do

If I am unable to make or share my own decisions, my Health Care Agent is authorized to:

- Follow the instructions I've written in this form.
- Make decisions based on what I've told them or what they believe I would want.
- Act in my best interest if my wishes are not known.
- Talk with my doctors to understand the situation before deciding.
- Read, share, and sign medical records as allowed by privacy laws (HIPAA and Minnesota law).
- Choose my doctors or care location.

Optional Permissions

My **initials** below show that I also give my Health Care Agent the ability to:

☐ **Continue to act as my Health Care Agent** even if our marriage or domestic partnership has ended or is in the process of ending.

☐ **Make decisions about my pregnancy** if I am pregnant and cannot make decisions for myself. These decisions should be based on my wishes and values.

Part 2: My Health Care Instructions

If I can't make or communicate a health care decision, my Health Care Agent will:

- Talk with my care team about my condition and treatment options.
- Ask about the risks, benefits, and what to expect in the future.
- Make choices that align with what I've shared here and what's best for me.

1. My Current Health and Treatment Choices

I currently have the following health conditions, diagnoses, or family health history:

_____

_____

_____

_____

My choices about treatment for these conditions are:

_____

_____

_____

_____

2. Cardiopulmonary Resuscitation (CPR)

What CPR means:
CPR is used if my heart or breathing stops. It can include chest compressions, shocks, a breathing tube, and medicine. It may cause injuries and may not work well for people with serious or long-term illnesses.

Choose one (initial next to your choice):

☐ **I want CPR to be attempted.**

☐ **I want CPR attempted unless** my medical team does not recommend it.

☐ **I do not want CPR attempted (allow a natural death).** If I choose this option, I should talk to my provider about a Provider Order for Life Sustaining Treatment (POLST) form.

3. Treatments That May Extend My Life

Medical treatments may include using a machine to help with breathing, providing food or fluids through tubes, restarting the heart, surgery, dialysis, antibiotics, and blood transfusions.

Choose one (initial next to your choice):

☐ I want comfort care only. I do not want treatments that prolong my life.

☐ I want comfort care, allowing short-term treatments if they are likely to help me recover.

☐ I want all available treatments to keep me alive.

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

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

_____

4. Pain and Comfort Care

I understand that:

- My care team will always try to manage my pain and keep me comfortable.
- Pain medicine might make me sleepy or less alert.
- I will be offered food and liquids by mouth as long as I can safely swallow.

Choose one (initial next to your choice):

☐ I want all pain and comfort treatments my care team recommends.

☐ I want the following limits on my pain treatment (*example: I do not want pain medicine that limits my ability to interact with others*):

_____

5. Organ Donation and Care of My Body After Death

Initial one, both, or leave blank:

☐ I authorize my Health Care Agent to make my funeral plans, including what happens to my body after I die. This can include things like cremation, burial, embalming, ceremonies, and other related choices.

☐ I authorize my Health Care Agent to make decisions about organ donation before and after my death. I understand that this means my Health Care Agent can start, continue, or stop any treatments needed to keep my organs, tissues, or eyes healthy until the donation has been completed.

Organ and Tissue Donation

Choose one (initial next to your choice):

☐ 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 part of my body.

Full Body Donation

I have arranged to donate my full body after death to the following organization:_____

☐ I have attached a copy of my donation paperwork.

Autopsy

If given the option to decide, I would like an autopsy conducted. ☐ Yes ☐ No

Part 3: My Health Care Instructions (optional)

These are my personal thoughts and values to help guide my Health Care Agent and care team.

What matters most to me in my everyday life:

Example: Being able to spend time with my family, enjoy nature, or care for my pets.

_____

_____

_____

_____

_____

_____

If I become very sick or near the end of life, I would like:
Example: To be at home with family, to have music playing, or to receive spiritual support.

I would feel my life is complete when:
Example: I have said goodbye to loved ones, recorded memories, or passed on values or keepsakes.

I would no longer want treatment if:
Example: It would only keep me alive but not allow me to talk, think clearly, or recognize my family.

To me, living well at the end of life means:
Example: Being comfortable, free from pain, and surrounded by people I care about.

I would like to spend my final days:
Example: At home, in hospice or a hospital, near nature, or surrounded by loved ones.

My Faith, Culture, or Community

Name of Organization:

City: State:

Contact Person: Phone:

Contact this person if I become seriously ill or after my death. ☐ Yes ☐ No

Part 4: Additional Notes (optional)

Add anything not covered above:

Part 5: Legal Authority

This form must be signed in front of two witnesses or a notary public. Your witnesses or notary cannot be your Health Care Agent.

I sign this form willingly. I understand it expresses my choices about future medical care.

Signature: _____ Date:_____

I am not able to sign my name, so the following person is signing for me at my request:

Printed name:_____

Signature: _____ Date: _____

Option 1 – Notary Public

In the State of Minnesota, County of_____ , on_____(date)

_____(name) acknowledged their signature on this form.

Notary Stamp

Notary Signature: _____

Notary Commission Expires:_____

Option 2 – Two Witnesses

This form was signed in front of the witnesses below. Witnesses are 18 years of age or older. Only one may be a health care provider or employee giving direct care to me.

Witness 1

Printed Name:_____

Signature: _____ Date:_____

Address:_____ City: _____ State:_____

Are you a health care provider or an employee of a provider giving direct care to this person? ☐ Yes ☐ No

Witness 2

Printed Name:_____

Signature: _____ Date:_____

Address:_____City:_____State:_____

Are you a health care provider or an employee of a provider giving direct care to this person? ☐ Yes ☐ No

Part 6: Recommended Next Steps

Now that I've completed my Health Care Directive, I should:

- Talk to my loved ones and Health Care Agent(s) about my wishes.
- Give copies to my Health Care Agent(s), my doctor, and any hospital where I receive care.
- Ask my provider to add it to my medical record.
- Keep a copy somewhere easy to find.

I will review this document whenever one of the "Five D's" happens:

1. **Decade** – I reach a new decade of life
2. **Death** – Someone close to me dies
3. **Divorce** – I go through a divorce or major family change
4. **Diagnosis** – I'm diagnosed with a serious illness
5. **Decline** – My health or ability to live independently changes

If my wishes change, I'll complete a new form and destroy old versions.