



Honoring Choices[®]

MINNESOTA

An initiative of the Twin Cities Medical Society.

Completing your Honoring Choices Health Care Directive

<input checked="" type="checkbox"/>	8-page Directive
<input type="checkbox"/>	4-page Directive
<input type="checkbox"/>	2-page Directive

Completing a directive is a very good thing for all adults to do. The form should be filled out after time spent thinking and talking with loved ones about your values and goals related to your future health care needs. Your directive should be detailed enough to allow people reading it to feel confident they can make decisions that would align with what you would say, if you were able to be a part of the conversation.

If you are in a situation where you cannot communicate, there will still be decisions that need to be made. If you have not talked with those closest to you about what you would want done, they will have to guess, and that is difficult.

**We can't do what you want
if we don't know what that is.**

For that reason it is important that all adults have Advance Care Planning conversations, and ideally write down their goals, values and preferences in a Health Care Directive. This document is your voice – so that in a situation where you are not able to communicate, you can still have a say in the decisions being made.

General notes:

- Write your name and the date on the bottom of every page just in case the pages become separated – that way it is an easy task to put all pages back in order.
- If you have instructions that are longer than the directive allows space for, you may attach additional pages, If you do this, indicate it by initialling one of several boxes throughout the directive (on page 4, 5, or 6).
- This is a “living document” meaning you should review and revise it periodically throughout your lifetime. Life circumstances change, and it's important that your directive stays up-to-date.

Page 1:

This is the page to identify yourself and your Agent(s). Please be sure to write legibly.

It is recommended that you choose one primary Agent, and you may name as many secondary Agents as you like. If you cannot choose between two people and want both as your Agent, one simple distinction might be to select the one that lives closest as your primary Agent and the other as a secondary Agent, and include a written note that you expect both your Agent and secondary Agent to work together to make decisions. Legally, you may name more than one Agent but it is highly recommended that you select one person to be the primary person for discussion and decision-making.



Remember that the first person you think of may or may not be the best person for this role. We recommend you read the Information Sheet on the Role of the Agent, available on the Honoring Choices website. And remember to **talk with the person you are asking to be your Agent**, to be sure they understand the role and are willing to accept it.

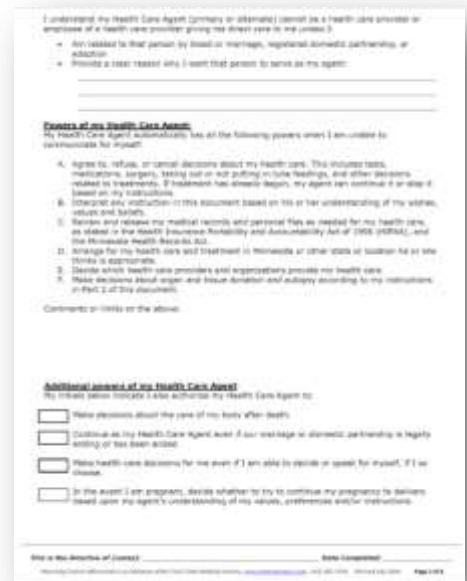
Additional notes on page 1:

1. The box referencing a “professional medical interpreter” is only checked if a language interpreter assists you with this form.
2. This directive is not meant for use for people who have a mental health diagnosis in which invasive treatments are used in treatment. There is a Minnesota Psychiatric Health Care Directive available for people in that situation; a link to this form is available on our website or you can request a copy from your mental health care provider.

Page 2:

This page outlines the legal rights and responsibilities of your Agent, as set by the Minnesota Legislature. You are allowed to change these responsibilities in your directive – you may use the blank space provided to describe your exact wishes.

Possible additional powers or your Agent are listed on the bottom of page 2. Please initial the boxes next to the statements you agree with to help your caregivers understand the scope of your Agent’s role. You may leave them blank if you so wish.



Page 3:

Here we ask you to start thinking about healthcare goals and values. Question 1, **A Decision for the Present**, is focused on your choices if something were to happen to you right now – in your current state of health. Accidents can happen to any of us at any time, and sudden illnesses can strike.

One way some people find helpful to think about it is “if you were in an accident today which caused your heart to stop beating, and/or caused you to stop breathing, what would you want?”

PART 2: My Health Care Instructions

My wishes and preferences for health care are as follows. I ask my Health Care Agent to communicate these wishes, and my health care team to honor them, if I cannot communicate or make my own choices. I have indicated a box below for the option I prefer for each situation.

NOTE: You do not need to write instructions about treatments to which you wish, but if it helps to do so, if you do not have written instructions, your agent will make decisions based on your best interests, as to your best interest if your wishes are unknown.

1. Cardiopulmonary Resuscitation: A Decision for the Present

This decision refers to a treatment choice I am making today based on my current health. Item 2 below (**Treatments to Prolong My Life: A Decision for the Future**) indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (circular pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and intubation. I understand that CPR can cause a life that does not always start. I also understand that CPR does not work as well for people who have chronic (long-term) disease or impaired functioning, or both. I understand that recovery after CPR can be painful and difficult.

Therefore:

I want CPR attempted if my heart or breathing stops.

OR

I want CPR attempted if my heart or breathing stops based on the current state of health, however, in the future if my health has changed, for example:

- I want an immediate choice of CPR and/or DNR
- I want no immediate choice of CPR and/or DNR if my heart or breathing stops
- I want some choice of long-term survival if my heart or breathing stops and CPR would likely improve suffering.

When my agent or I or I am able, I will discuss CPR with my health care team. My choice in Section 3, **Treatment Preferences for Section 3: Treatments to Prolong My Life** below should be considered when making this decision.

OR

I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand I should discuss this option I should let my health care provider about writing a Do Not Resuscitate (DNR) order.

What is the address of the person I am designating as my Health Care Agent? _____ State: _____

Address: _____ City: _____ State: _____ Zip: _____

Page 4:

This page takes you further into thinking about healthcare choices. Question 2 offers you the chance to write in any directions or information that is important to you based on your healthcare, history, or other reasons. You do not have to write anything here if nothing comes to mind.

Examples of things some people have written here include preferences about pain medication related to level of awareness, interest in alternative therapies, time limits on treatment trials (please be specific), etc.

Question 3 is similar to question 1 on page 3, in that it asks you to consider life-sustaining treatment choices. The difference is in this question you are asked to imagine a future scenario where you may be elderly and frail, or where you may be diagnosed with a chronic or life-threatening disease.

Please note that efforts to keep you comfortable, which include some types of medication, as well as food and liquid offered by mouth, are offered to all patients. If you do not want these comfort measures, you should describe your preferences here.

2. Treatments to Prolong My Life: A Decision for the Future

This decision refers to a treatment choice I am making today based on my current health. Item 1 above (**Cardiopulmonary Resuscitation: A Decision for the Present**) indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (circular pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and intubation. I understand that CPR can cause a life that does not always start. I also understand that CPR does not work as well for people who have chronic (long-term) disease or impaired functioning, or both. I understand that recovery after CPR can be painful and difficult.

Therefore:

I want to allow a natural death. I understand I should discuss this option I should let my health care provider about writing a Do Not Resuscitate (DNR) order.

OR

I do not want to allow a natural death. I want to allow a natural death. I understand I should discuss this option I should let my health care provider about writing a Do Not Resuscitate (DNR) order.

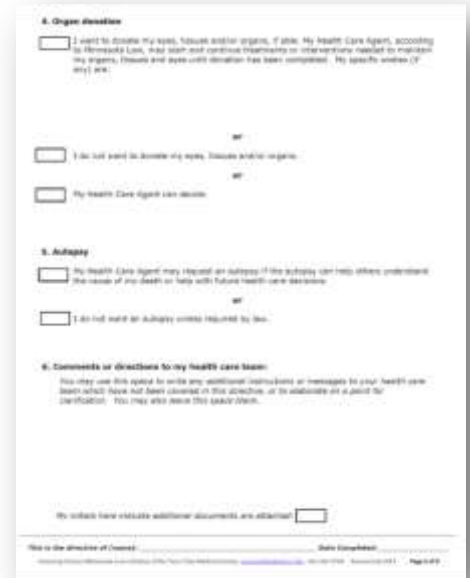
What is the address of the person I am designating as my Health Care Agent? _____ State: _____

Address: _____ City: _____ State: _____ Zip: _____

Page 5:

This page focuses on what happens after you die. You are asked for your thoughts on organ donation and autopsy. There is blank space left for you to add any additional information you would like to. Some things that people include on this page:

- Preferences on hospice care options
- Preferences regarding burial, cremation, or other options (note there is a space to describe preferences on funerals, memorial services, or other arrangements on page 6)
- Donation of your entire body to science (note this MUST be arranged ahead of time with the recipient organization – your directive alone cannot arrange for this type of whole-body donation)
- Contact information and other details about any pre-arranged plans you have put in place.



Page 6:

Though this page says “Optional” at the top, it is the page that can give the most information to your family, friends, and healthcare team about your personal preferences, values, and choices. We strongly encourage you to answer the questions thoughtfully and thoroughly.

Some examples of things people have included on this page:

- Play list of music they would like played in their room
- Requests that loved ones keep them “looking nice” with combed hair and clean linens
- Requests for visits from pets
- Instructions about wanting or not wanting prayers, spiritual rituals, or other faith-related traditions
- Notes about who to notify (faith leaders, specific friends, extended family members, etc) and who to not notify (it is acceptable to indicate your feelings of what you do not want to happen in your final days)
- Information about memorial services including music, readings, guests, food and beverage, location, and other details
- Personal messages to family/loved ones (for example “please surround my bed and share stories and memories, and laugh together at the joy we have shared.” or “It’s important to me that you all get along, so if you find yourself arguing about my care, take some time to calm down and start again.”)



Page 7:

This page turns your directive into a legal document. You must sign and date it (or authorize another to sign for you if you are unable to sign yourself).

Then, either have your directive notarized **or** have it signed by two adult witnesses (neither of whom can be your Agent or secondary Agent, and only one of whom can be an employee of your healthcare provider.) You do not need both witnesses and a notary.

Part 4: Legal Authority

NOTE: Under Minnesota law, 2 witnesses or a notary public must verify your signature and the date. Your witnesses or notary public cannot be named on your primary or alternate Health Care Agent.

I have made this document willingly. I am thinking clearly. This document states my wishes about my future health-care decisions.

Signature: _____ Date: _____

I consent 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 named above, I must withdraw here. One witness cannot be a provider or an employee of the provider giving direct care on the date this document is signed.

Witness 1: _____ Witness 2: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Print name: _____ Print name: _____

Address (optional): _____ Address (optional): _____

or

Notary Public: _____

In the presence of _____ (two) _____ (two)

I acknowledge that I am the person who signed this document or that I am the authorized person signing this document in your name or on behalf of the named person or Health Care Agent in this document.

Signature of Notary: _____ Notary State: _____

Notary Commission Number: _____

This is the declaration of the declarant. State (required): _____

Signature: _____

Page 8:

This page offers helpful information on what to do after your directive is complete. Keep the **original** yourself, in a safe but accessible place (not your safe deposit box or on file with your attorney, though you could put *copies* in both those places.). Read the “Five Ds” and remember to revisit your directive over time.

You should give copies to people who will be involved in your future health care:

- Your Agent, as well as your secondary Agent(s)
- Your primary care provider
- Your local hospital (even if you have never been a patient there, they will accept your directive and start a medical file for you so that, if you ever are admitted, it will be on file)

Part 5: Next Steps

Now that I have completed my Health Care Directive, I will also:

- Tell my primary and alternate Health Care Agents and make sure they feel able to do that important job for me in the future.
- Give my primary and alternate Health Care Agents a copy of this completed Health Care Directive.
- Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Health Care Agents are, and what the wishes are.
- Give a copy of this completed Health Care Directive to the doctor and other health care providers, and make sure they understand and will follow my wishes.
- Keep a copy of my Health Care Directive where it can be easily found.
- Take a copy of the Health Care Directive with me if I am admitted to a health care facility, and see that it is placed in my medical record.
- Review my health care wishes every time I have a physical exam or whenever any of the “Five Ds” occur.

Five Ds

Deaths when I reach each new decade of my life

Illness whenever I experience the death of a loved one

Changes when I experience a divorce or other major life change

Diagnosis when I am diagnosed with a serious health condition

Decline when I experience a significant decline or deterioration of an existing health condition, especially when I am unable to live on my own.

Copies of this document have been given to:

Primary (and/or) Health Care Agent (listed on page 1 of this document)

Name: _____ Telephone: _____

Alternate Health Care Agent (listed on page 1 of this document)

Name: _____ Telephone: _____

Health Care Provider(s)

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

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.

This is the declaration of the declarant. State (required): _____

Signature: _____

Additionally, some people choose to give copies to:

- Close family members and friends who are not the chosen Agent, but will likely be involved in your care – this avoids surprises later on, and allows them to be aware of your choices in order to support your Agent
- Personal attorney to have on file with copies of your will or other legal documents
- Faith Leader, especially if you have included a request for that leader to be involved in your care and/or to lead a memorial service

Questions? Contact Honoring Choices Minnesota at info@HonoringChoices.org or 612-362-3705