Honoring Choices®
MINNESOTA

保健願望：簡易格式[1]
Wishes for Health Care: Short Form[1]
明州醫療照護事前指示[2]
Minnesota Health Care Directive[2]

請繼續填寫另一頁
See other side for completion directions

姓名：_____ 出生日期（月/日/年）：_____
Full Name Date of Birth (MM / DD / YYYY)

1. **我授權以下人仕為我的醫療保健代理人**。 如果我自己無法溝通或做出決定，此人將為我做出有關醫療保健的決定：

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

姓名_____ 關係_____
Name Relationship

手機_____ 其他電話_____
Cell Phone Other Phone

如果我以上的醫療保健代理人不能或無法為我做有關醫療照護方面的決定時，我的替代醫療保健代理人如下：

I appoint this person as my alternate health care agent in the event my primary healthcare agent is not available:

姓名_____ 關係_____
Name Relationship

手機_____ 其他電話_____
Cell Phone Other Phone

2. **以下有關我醫療保健的說明**（例如我的價值觀和信仰；我想要的或不想要的醫療照護；我對特定醫療或情況的看法）。如果您需要更多空間填寫，可以在另一頁繼續。

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

_____

_____

_____

簽名_____ 日期_____
Signature Date

公證印章
Notary Seal

第一種方式：明尼蘇達州承認的公證
Notary Public in the State of Minnesota

明州_____郡，
County of

於_____（月/日/年），
On (MM/DD/YYYY

在我_____的面前，
Before me （寫上公證人的名字和頭銜） (Name and title of officer)

親自到場的_____
Personally appeared （寫上授權人的名字）(Name of principal)

承認他/她在本文檔上的簽名或承認他/她已經授權給簽署本檔的人為他/她簽此文檔。 I 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:

公證人簽名_____
Signature of Notary

我的公證委任証有效期至_____（月/日/年）
My commission expires (MM/DD/YYYY

第二種方式：兩名見證人的聲明書：
OR statement of two (2) witnesses

第一見證人_____ 第二見證人_____
Witness 1 Witness 2

日期_____ 日期_____
Date signed Date signed

見證人正楷姓名_____ 見證人正楷姓名_____
Print name Print name

（證人必須年滿 18 歲及以上，並且不是您的主要或替代醫療護理代理人。不能有一名證人是您的醫療保健提供者或您的醫療保健提供者的僱員。）
(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] *如果您希望更全面地描述您的醫療保健願望，可以提供一份詳細的表格。*
[1] *A long form is available if you wish to more fully describe your healthcare wishes.*

[2] *本文件不適用於任何侵入性心理精神健康治療（電痙攣治療或精神安定藥物）。*
[2] *This document will not apply to any intrusive mental health treatments (electroconvulsive therapy or neuroleptic medications)*

我必須完成這項醫療保健指令嗎？ Do I have to complete this Health Care Directive?

不。您可以在今天或晚些時候完成，也可以拒絕完成。但是填寫此表格將有助於確保您得到您想要的照護。把您的選擇寫在書面上可以幫助您的親人知道他們是否在做您想做的護理。

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.

A）我被要求什麼信息？ What information am I being asked for?

問題 1: 這個問題是與您的醫療保健“代理人”有關。如果您不能做出醫療保健決定，您選擇的代理人是您的發言人並為您做出醫療保健決定的人。您要考慮授權一個熟悉您並了解您價值觀的家庭成員或朋友為您的代理人。**您要向您的代理人顯示此文件並與他/她談論這件事,這是很重要的。** 請您打印多份副本給予您的醫療保健代理人、醫療保健提供者以及您生活中的其他重要人物。

Question 1: This question is about your health care "agent." Your agent is someone you choose to speak and make healthcare 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.

問題 2 *(可選擇填寫)*: 這個問題是關於醫療保健和您可能有的其他願望。您可能有特定的或一般的指示。您的指示可能包括：

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:

- 您對醫療護理的意願、您所看重和對醫療護理的偏好
  your goals, values, and preferences about medical care
- 您想要或不想要的醫療類型
  the types of medical treatment you would want or not want
- 您希望您的代理人為您做出怎樣的決定
  how you want your agent or agents to decide
- 您希望獲得護理的地方（如家中或醫院）
  where you would like to receive care (such as at home or a hospital)
- 您是否願意捐贈您的器官組織和眼睛
  whether or not you would like to donate your organs, tissues, and eyes

公證人或見證人 Notary Public or Witness

公證人或兩名見證人必須核實您在此健康護理指令上的簽名。見證人必須年滿十八歲及以上，並且不是您的主要醫療護理人或替代醫療護理人。至少有一名證人不是您的醫療保健提供者或不是您的醫療保健提供者的僱員。

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.

B）完成此健康護理指令後應該怎麼做？ What should I do after I complete this Health Care Directive?

如果您尚未告訴您指定的人為您的主要和替代醫療保健代理人，我們會建議您通知他或她, 確保他或她覺得能夠在未來為您做這個重要的任務。您要確保將您的健康護理指令副本提供給您的醫療保健提供者。您要把您的健康護理指令副本交給您的醫護人員和家人或其他人, 並且保留額外的副本作為您個人的記錄。

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.

C）如果我有問題，我應該問誰？ Who can I talk with if I have questions?

您的醫護人員可以回答您的問題或疑慮。他或她也可將您轉介給高等護理計劃協調者尋求幫助。

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

使用以下的空間繼續填寫關於您的健康護理的意願（首頁的問題 2），或者附加的意願。

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