

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 an 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 "N/A" 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 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.

My Primary Health Care Agent is:

Name: _____ **Relationship:** _____

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Patient Name: _____ Date of Birth: _____

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My First Alternate Health Care Agent is (optional):

Name: _____

Address: _____

(cont.) _____

Home Phone: _____

Cell Phone: _____

Relationship: _____

My Second Alternate Health Care Agent is (optional):

Name: _____

Address: _____

(cont.) _____

Home Phone: _____

Cell Phone: _____

Relationship: _____

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 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:

- a. Follow my health care instructions in this document.
- b. Follow any instructions I have given to my agent if I have not provided guidance in a particular situation.
- c. Make decisions in my best interest if my wishes are not known.
- d. Make decisions for me based on the input from my medical providers and/or other medical professionals.
- e. Make health care decisions for me even if I still have decision-making capacity. I understand that I may change my mind about this if I have decision-making capacity.

2. Powers of my Health Care Agent:

My Health Care Agent automatically has all 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:

- a. 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.
- b. Interpret instructions in this document based on my agent's understanding of my wishes, values, and beliefs.
- c. 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 the Minnesota Health Records Act.
- d. Arrange for my care and treatment in any state or location my agent thinks is appropriate.
- e. Decide which health care providers and organizations provide my health care.
- f. To carry out my instructions as listed in the anatomical/organ donation section of this document, and to make these decisions before and/or after my death.

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. I want my Health Care Agent(s), health care team, and/or others I trust, to know my following 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:

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

Patient Name: _____

Date of Birth: _____

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 or decisions, 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 are, 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 I require life-sustaining interventions to keep me alive, I want my decision-makers to know:

Patient Name: _____ Date of Birth: _____

(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:

- It is standard practice for health care teams to alleviate pain and suffering to the fullest extent possible.
- Sometimes adequately controlling my pain means that I can no longer think clearly or be conscious.
- My wishes for symptom management, for example the treatment of pain, will be considered by my team.
- 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."
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Organ Donation & Care of My Body After Death:

Choose none, one, or both as applicable:

- I authorize my Health Care Agent to make funeral arrangements including body disposition. Body disposition means how my body is handled after death. This can include, but is not limited to, decisions such as cremation, burial, embalming, ceremonial processes, and other related decisions.
- I authorize my Health Care Agent to decide about organ donation before and/or after my death. By choosing this option, 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:

- c. If given the option to decide, I would like an autopsy conducted. **Circle one:** YES NO

Patient Name: _____

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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 in this document.

Notary Stamp:

Notary Signature: _____

Notary Commission Expires (date): _____

Patient Name: _____ Date of Birth: _____

