

Health Care Directive



I _____ understand this document allows me to do ONE
(principal)

or BOTH of the following:

1. Name another person to act as my health care agent to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in Part II of this document, if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

2. Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care, and my family, in the event that I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF. I know I can change my agent or alternate agent at any time, and I know I do not have to appoint an agent or an alternate agent.

(If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go on to Part II.)

When I am unable to decide or speak for myself, I trust and appoint _____ to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me: _____.

Telephone number of my health care agent: _____.

Address/city/state of my health care agent: _____

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint _____ to be my health care agent instead.

Relationship of my alternate health care agent to me: _____.

Telephone number of my alternate health care agent: _____.

Address/city/state of my alternate health care agent: _____

_____.

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF (I know I can change these choices.)

My health care agent is automatically given the powers listed below in A through D. My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

- A. Make any health care decisions for me. This includes the power to give, refuse or withdraw consent to any care, treatment, service or procedure. This includes deciding whether to stop or not to start care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.
- B. Choose my health care provider.
- C. Choose where I live and receive care and support when those choices relate to my health care needs.
- D. Review my medical records and have the same rights that I would have to give my medical records to other people.

If I do NOT want my health care agent to have a power listed in A through D — or if I want to LIMIT any power in A through D, I MUST say that here:

_____.

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

_____ (1) To decide whether to donate my organs when I die.

_____ (2) To decide what will happen to my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

PART II: HEALTH CARE INSTRUCTIONS

Complete Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional, but would be very helpful to your agent. However, if you chose not to appoint any agent in Part I, you MUST complete some or all of Part II if you wish to make a health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed so long as they address my needs.

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE. I know I can change these choices or leave any of them blank.

I want you to know these things about me to help you make decisions about my health care.

My goals for my health care: _____

My fears about my health care: _____

My spiritual or religious beliefs and traditions: _____

My beliefs about when life would no longer be worth living: _____

My thoughts about how my medical condition might affect my family:

Below are listed some situations I may encounter. I recognize these cannot exactly predict what might happen, but I instruct my agent and my care providers to use this information to the best of their ability in making treatment decisions for me if I am unable to speak for myself. *I understand that I WILL BE provided medically appropriate life-supporting treatments UNLESS I DIRECT OTHERWISE.* (Definition: "Life-supporting treatment" means any medical procedure, device, or medication that keeps me alive. These may include a breathing machine (ventilator), cardiopulmonary resuscitation (CPR), artificial food and water (including tube feedings and IVs), surgical procedures, dialysis, antibiotics to treat infections, and/or blood transfusions).

1. If my death is imminent, with no reasonable expectation of recovery (choose one of the following):

- I direct that my dying process NOT be extended by any means, including the use of cardiopulmonary resuscitation, artificial ventilation, AND the administration of artificial nutrition and hydration. I do want medication that will bring me comfort and relief from my symptoms.
- I WOULD WANT artificial nutrition and hydration to be continued, along with medications that will bring me comfort and relief from my symptoms.
- I WOULD WANT all appropriate and medically indicated life-supporting treatment.

ADDITIONAL COMMENTS: _____

2. If I am suffering from a chronic, progressive illness that will eventually and inevitably lead to my death (choose one of the following):

- I direct that my dying NOT be extended by any means, though I do want medication that will bring me comfort and relief from my symptoms.
- I WOULD WANT artificial nutrition and hydration to be continued, along with medications that will bring me comfort and relief from my symptoms.
- I WOULD WANT all appropriate and medically indicated life-supporting treatment.

ADDITIONAL COMMENTS: _____

_____.

3. If I am permanently unconscious, whether or not my death is imminent (choose one of the following):

- I direct that all artificial life support be discontinued and that appropriate pain relief medications be provided.
- I request that a TRIAL OF THERAPY be given for a reasonable time, to be determined by my agent and my physicians. This therapy may include all treatments necessary to restore me to a reasonable quality of life. Should it be determined that such treatments are futile, I would then want all artificial life supports discontinued.
- I WOULD WANT artificial nutrition and hydration to be continued, along with medications that will bring me comfort and relief from my symptoms.
- I WOULD WANT all appropriate and medically indicated life-supporting treatment.

ADDITIONAL COMMENTS: _____

_____.

4. If I have a serious and/or devastating illness or injury for which there is no reasonable medical expectation for recovery and which will likely lead to my death (choose one of the following):

- I direct that all artificial life support be discontinued and that appropriate pain relief medications be provided.
- I request that a TRIAL OF THERAPY be given for a reasonable time, to be determined by my agent and my physicians. This therapy may include all treatments necessary to restore me to a reasonable quality of life. Should it be determined that such treatments are futile, I would then want all artificial life supports discontinued.
- I WOULD WANT artificial nutrition and hydration to be continued, along with medications that will bring me comfort and relief from my symptoms.
- I WOULD WANT all appropriate and medically indicated life-supporting treatment.

ADDITIONAL COMMENTS: _____

_____.

I also want to communicate these additional preferences regarding my future health care:

If I am unable to speak for myself and if a choice is possible and reasonable, I would prefer my primary physician to be:

Dr: _____

If I am dying and if a choice is possible and reasonable, I would prefer to receive my care:

___ At home

___ At a hospital. Which one? _____

___ At a nursing home. Which one? _____

___ Through a hospice. Which one? _____

___ From other health care providers. Which ones? _____

My wishes about donating tissues, organs, or other body parts after I die:

___ I **DO** wish to donate tissues, organs, or other body parts after I die

___ any needed and useable parts

___ only the following body parts: _____.

___ Limitations or special wishes I have _____.

___ I **DO NOT** wish to donate tissues, organs, or other body parts.

ADDITIONAL THOUGHTS AND INSTRUCTIONS: _____

_____.

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It must also be either verified by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly. I agree with everything that is written in this document, and I have made this document willingly.

(Principal's Signature)

Date Signed: _____

Date of Birth: _____

Address: _____

If I cannot sign my name, I can ask someone to sign this document for me.

(Signature of the person whom I asked to sign this document for me.)

Printed name of the person whom I asked to sign this document for me.)

Option 1: Notary Public

In my presence on _____, 20____, _____
acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

(Signature of Notary)

Seal Below

Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day that I sign this document.

Witness One:

- (i) In my presence on _____, 20 ____, _____
acknowledged his/her signature on this document or acknowledged that he/she
authorized the person signing this document to sign on his/her behalf.
- (ii) I am at least 18 years of age.
- (iii) I am not named as a health care agent or an alternate health care agent in this
document.
- (iv) If I am a health care provider or an employee of a health care provider giving
direct care to the person listed above in (A), I must initial this box. []

I certify that the information in (i) through (iv) is true and correct.

(Signature of Witness One)

Address: _____
_____.

Witness Two:

- (i) In my presence on _____, 20 ____, _____
acknowledged his/her signature on this document or acknowledged that he/she
authorized the person signing this document to sign on his/her behalf.
- (ii) I am at least 18 years of age.
- (iii) I am not named as a health care agent or an alternate health care agent in this
document.
- (iv) If I am a health care provider or an employee of a health care provider giving
direct care to the person listed above in (A), I must initial this box. []

I certify that the information in (i) through (iv) is true and correct.

(Signature of Witness Two)

Address: _____
_____.

REMINDER

Keep this document with your personal papers in a safe place that you can easily access. Give signed copies to your physicians, family, close friends and a health care agent, if you have designated one. Discuss your wishes and concerns with your loved ones and with your doctor. Make sure he or she is willing to follow your directions.

If you are admitted to a hospital or nursing facility, or are receiving care from a home care agency or hospice, make sure a copy of this document is included as a part of your medical record. Should you have any questions, ask your doctor for guidance, or call the hospital of your choice and speak with a patient representative, a chaplain or a social worker.

This form has been adapted from, and is in full compliance with, the 1998 Minnesota Health Care Directive law, chapters 145B & 145C. It has been reviewed and endorsed by the Allina Ethics Network and adopted by Allina Health System to promote advance care planning and sound decision-making. Guidance can be obtained by calling any Allina hospital or clinic.

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