Honoring Choices® MINNESOTA
An initiative of the Twin Cities Medical Society.

Health Care Directive English

Introduction

I have completed this Health Care Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

NOTE: *This document does not apply to intrusive mental health treatments, defined as electroconvulsive therapy or neuroleptic medications.*

Any advance directive document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

My telephone numbers: (home) _____(cell) _____

☐ My initials here indicate a professional medical interpreter helped me complete this document.

Part 1: My Health Care Agent

If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the following person to communicate my wishes and make my health care decisions. My Health Care Agent must:

- Follow my health care instructions in this document.
- Follow any other health care instructions I have given to him or her.
- Make decisions in my best interest.

My Primary (main) Health Care Agent is:

Name: _____ Relationship: _____

Telephone numbers: (H)_____ (C)_____ (W)_____

Full address: _____

If I cancel my primary agent's authority, or if my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate Health Care Agent.

My Alternate Health Care Agent is:

Name: _____ Relationship: _____

Telephone numbers: (H)_____ (C)_____ (W)_____

Full address: _____

I understand my Health Care Agent (primary or alternate) cannot be a health care provider or employee of a health care provider giving me direct care to me unless I:

- Am related to that person by blood or marriage, registered domestic partnership, or adoption
- Provide a clear reason why I want that person to serve as my agent:

_____

_____

_____

Powers of my Health Care Agent:
My Health Care Agent automatically has all the following powers when I am unable to communicate for myself:

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 other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.
B. Interpret any instruction in this document based on his or her 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 health care and treatment in Minnesota or other state or location he or she thinks is appropriate.
E. Decide which health care providers and organizations provide my health care.
F. Make decisions about organ and tissue donation and autopsy according to my instructions in Part 2 of this document.

Comments or limits on the above:

Additional powers of my Health Care Agent:
My initials below indicate I also authorize my Health Care Agent to:

☐ Make decisions about the care of my body after death.

☐ Continue as my Health Care Agent even if our marriage or domestic partnership is legally ending or has been ended.

☐ Make health care decisions for me even if I am able to decide or speak for myself, if I so choose.

☐ In the event I am pregnant, decide whether to try to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences and/or instructions.

Part 2: My Health Care Instructions

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

***NOTE**: You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or in 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 3 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 (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization**.** I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases or impaired functioning, or both. I understand that recovery from 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 my current state of health. However, in the future if my health has changed; for example:

- I have an incurable illness or injury and am dying
- I have no reasonable chance of survival if my heart or breathing stops
- I have little chance of long-term survival if my heart or breathing stops and CPR would cause significant suffering

then my agent or I (if I am able) should discuss CPR with my health care team. My choices in **Section 2: Treatment Preferences** and **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 if I choose this option I should see my health care provider about writing a Do Not Resuscitate (DNR) order.

2. Treatment Choices: My Health Condition

My treatment choices for my specific health condition(s) are written here. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

My initials here indicate additional documents are attached: ☐

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

If I can no longer make decisions for myself, and my health care team and agent believe I will not recover my ability to know who I am, I want:

NOTE: With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

☐ To **stop or withhold all treatments** that extend my life. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics.

or

☐ **All treatments recommended** by my health care team This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics. I want treatments to continue until my health care team and agent agree such treatments are harmful or no longer helpful.

Comments or directions to my health care team:

4. Organ donation

☐ I want to donate my eyes, tissues and/or organs, if able. My Health Care Agent, according to Minnesota Law, may start and continue treatments or interventions needed to maintain my organs, tissues and eyes until donation has been completed. My specific wishes (if any) are:

or

☐ I do not want to donate my eyes, tissues and/or organs.

or

☐ My Health Care Agent can decide.

5. Autopsy

☐ My Health Care Agent may request an autopsy if the autopsy can help others understand the cause of my death or help with future health care decisions.

or

☐ I do not want an autopsy unless required by law.

6. Comments or directions to my health care team:

You may use this space to write any additional instructions or messages to your health care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.

My initials here indicate additional documents are attached: ☐

Part 3: My Hopes and Wishes *(Optional)*

I want my loved ones to know my following thoughts and feelings:

The things that make life most worth living to me are:

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

My thoughts about specific medical treatments, if any:

My thoughts and feelings about how and where I would like to die:

If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (rituals, prayers, music, etc.):

Religious affiliation: I am of the _____ faith, and am a member of _____ faith community in (city) _____.
Please notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like my funeral to include, if possible, the following (people, music, rituals, etc.):

Other wishes and instructions:

My initials here indicate additional documents are attached: ☐

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 as 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:**_____

If I cannot sign my 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 this line: _____. One witness cannot be a provider or an employee of the provider giving direct care on the date this document is signed.

Witness 1:

Signature _____

Date: _____

Print name

_____

Address (optional)

_____

_____

Witness 2:

Signature _____

Date: _____

Print name

_____

Address (optional)

_____

_____

Or

Notary Public:

In the state of Minnesota, County of _____.

In my presence on _____ (date), _____ (name) acknowledged his or her signature on this document or that he or she authorized the person signing this document to sign on his or her behalf. I am not named as a Health Care Agent in this document.

Signature of notary: *Notary stamp:*

My commission expires (date):

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 this 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 Agent is, and what my wishes are.
- Give a copy of this completed Health Care Directive to my doctor and other health care providers, and make sure they understood and will follow my wishes.
- Keep a copy of my Health Care Directive where it can be easily found.
- Take a copy of my Health Care Directive any time I am admitted to a health care facility, and ask that it be placed in my medical record.
- **Review my health care wishes every time I have a physical exam or whenever any of the "Five D's" occur**:

Decade	when I start each new decade of my life.
Death	whenever I experience the death of a loved one.
Divorce	when I experience a divorce or other major family 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 (main) 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/Clinic

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

If my wishes change, <u>I will fill out a new Health Care Directive</u>. 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.