MINNESOTA

EDUCATION

Health Care Directive

Making Your Health Care Choices Known

Allina Health

Minnesota version

My Health Care Directive

My health care directive was created to guide my health care agent and family, friends or others close to me to make health care decisions on my behalf if illness or injury prevents me from deciding or communicating them myself.

I understand that it is my responsibility to talk about my wishes, goals and values with my health care agent and family, friends or others close to me. This will help them understand my wishes, goals and values to the best of their ability and help my health care agent make decisions for me that are in line with my health care choices.

I understand that my health care agent and my health care provider(s) may not be able to honor my wishes, goals and values in every circumstance.

I created this document with much thought.

Any health care directive document created before this is no longer valid.

My legal name: ____

My date of birth: ____

My address: ____

My telephone number: ____

My cell phone number: ____

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Part 1: My Health Care Agent

I have chosen a health care agent to speak for me if:

- I am unable to communicate my wishes, goals and values, and health care decisions due to illness or injury

  or

- my health care providers have determined I am not able to make my own health care decisions.

When choosing a health care agent, I have considered his or her ability to willingly make decisions based on my choices. I trust this person to follow my wishes, goals and values under times of stress.

I understand that my health care agent must be 18 years of age or older.

Note: If the person you choose to be your health care agent is a health care provider giving care to you now or possibly in the future, you should **not** select this person as your health care agent unless:

- the person is related to you by blood, marriage, registered domestic partnership or adoption

  or

- the person has a relationship with you other than as your health care provider, such as a neighbor or long-time friend.

My primary (main) health care agent is:

Name: ____

Relationship: ____

Address: ____

Telephone (Home) ____________________ (Cell) ____________________ (Work) ____________________

Alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent is not available or willing to serve as my health care agent:

Name: ____

Relationship: ____

Address: ____

Telephone (Home) ____________________ (Cell) ____________________ (Work) ____________________

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Additional alternate health care agents

Note: You may leave this page blank.

2nd alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent and my first alternate health care agent are not available or willing to serve as my health care agent:

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Telephone (Home) ____________ (Cell) ____________ (Work) ____________

3rd alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent and other alternate health care agents are not available or willing to serve as my health care agent:

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Telephone (Home) ____________ (Cell) ____________ (Work) ____________

4th alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent and other alternate health care agents are not available or willing to serve as my health care agent:

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Telephone (Home) ____________ (Cell) ____________ (Work) ____________

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Powers of my health care agent

My health care agent automatically has all of the following powers when I am unable to make my own health care decisions:

- Make decisions about my health care, including decisions to start, stop or change treatments for me. This includes taking out or not putting in tube feedings, tests, medicine, surgery, and other decisions about treatments including mental health treatments or medicines. If treatment has already begun, my health care agent can continue or stop it based on verbal and/or written instructions.
- Interpret any instructions in this document according to his or her understanding of my wishes, goals and values.
- Review and release my medical records, health information and other personal records as needed for my health care as a personal representative under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state law.
- Arrange for my health care and treatment in any state or location he or she thinks is appropriate.
- Decide which health care providers and organizations provide my care and treatment.

Note: Your health care agent cannot make decisions about your finances. Consider talking with a lawyer about filling out a Financial Power of Attorney document if you would like to make sure you give someone power to make financial decisions or complete financial transactions on your behalf.

Additional powers of my health care agent

If I want my health care agent to have any of the following powers, **I have initialed** the box(es) below.

☐ 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.

☐ If I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon his or her understanding of my wishes, goals, values and instructions.

Limitations of my health care agent's powers

If I want to limit my health care agent's authority on the decisions or actions he or she may take, I have written them below.

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Part 2: My Health Care Instructions

My choices for my health care are as follows. I ask my health care agent to represent these choices, and my health care providers to honor them if I can't communicate or make my own decisions.

Note: This document gives your health care agent authority to make decisions only when:

- your health care providers determine you can't make them
- you have requested that your health care agent make decisions for you even if you are able to decide or communicate yourself.

Cardiopulmonary resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions (forceful pushing on the chest to make the blood circulate), medicines, electrical shocks, a breathing tube and a hospital stay.

I understand that:

- CPR can save a life but it does not always work
- CPR does not work as well for people who have chronic (long-term) diseases
- recovery from CPR can be painful and difficult.

I have initialed the option I prefer for this situation.

My choice about CPR

☐ **I want CPR** attempted if my heart or breathing stops in all circumstances.

☐ **I want CPR** attempted if my heart or breathing stops **except when** my health care provider has determined that I have little or no reasonable chance of survival even with CPR.

☐ **I do not want CPR** attempted if my heart or breathing stops. I prefer a natural death. If I choose this option, I should talk with my health care provider.

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Treatments to extend my life

If my health care providers determine I am in a vegetative state, or that I have a permanent brain injury that means it is very likely I will not regain consciousness or recover my ability to know who I am, I choose the following.

Note: With any choice, you will continue to be offered pain and comfort medicines as well as food and liquids by mouth if you are able to swallow.

I have initialed the option I prefer for this situation.

My choice is:

☐ **I would want to stop or withhold all treatments** that are extending my life at this time. This includes, but is not limited to, tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), CPR and antibiotics (medicines).

☐ **I would want all the treatments** recommended by my health care team until they agree that such treatments are harmful and no longer helpful. This includes, but is not limited to, tube feedings, IV fluids, respirator/ventilator, CPR and antibiotics.

☐ **I would want to receive limited treatment.** I would want to receive certain types of care in certain circumstances, as I've written below. For example, you may write that you want to live on life support until all of your family has arrived.

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Terminal illness

A terminal illness is an active and worsening condition that can't be cured and is expected to lead to death.

Note: With any choice, you will continue to be offered pain and comfort medicines as well as food and liquids by mouth if you are able to swallow.

I have initialed the option I prefer for this situation.

If I have a terminal illness, my choice is:

☐ **I would want to stop or withhold all treatments** that are extending my life. This includes, but is not limited to, tube feedings, IV fluids, respirator/ventilator, CPR and antibiotics.

☐ **I would want all the treatments** recommended by my health care team until they agree that such treatments are harmful and no longer helpful. This includes, but is not limited to, tube feedings, IV fluids, respirator/ventilator, CPR and antibiotics.

☐ **I would want to receive limited treatment.** I would want to receive certain types of care in certain situations, as I've written below. For example, you may write that you want to have antibiotics to treat infections.

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Other treatment choices (optional)

Note: Use this space to write any treatment choices you may have for your specific condition. For example, if you have diabetes you may write your thoughts on dialysis. You may leave this space blank.

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☐ I chose to leave this section blank. (inital box)

Organ donation

Organ donation is donating organs, eyes, tissues or any other body part to other people in need.

I have initialed the option I prefer for this situation.

☐ **I do not** want to donate my organs, eyes, tissues or any other body parts. I do not allow this donation after I die.

☐ **I do** want to donate any or all of my organs, eyes, tissues or other body parts. I allow this donation after I die. My health care agent is authorized to start or continue supportive treatments or any interventions needed to maintain my organs, eyes, tissues or any other body part until donation has been completed.

☐ **I do** want to donate, but I want to **limit** my tissue and organ donations. I authorize the limited donation, as I've written below, after I die. My health care agent is authorized to start or continue supportive treatments or any interventions needed to maintain my organs, eyes, tissues or any other body part until donation has been completed.

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☐ **I have not decided** whether to donate any or all of my organs, eyes, tissues or other body parts. I authorize my health care agent to make this decision after I die.

Note: Please sign and date any additional pages you are attaching to this document.

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Autopsy

An autopsy is done to confirm cause of death or to advance medical science.

I have initialed the option I prefer for this situation.

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

☐ **I do** allow my health care agent to request an autopsy if it can help others understand the cause of my death or help my family members make decisions about their future health care.

☐ **I have not decided** whether I would allow an autopsy. I authorize my health care agent to make this decision after I die.

Comments or instructions to health care providers (optional)

Note: Use this space to write any additional instructions or messages to your health care team which have not been covered in this health care directive, or to expand or clarify your wishes, goals and values. You may leave this space blank.

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☐ I chose to leave this section blank. (inital box)

Note: Please sign and date any additional pages you are attaching to this document.

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Other comments or instructions for my health care agent (optional)

Note: Use this space to write any additional instructions or messages to your health care agent which have not been covered in this health care directive. You may leave this space blank.

For example, you may write down the names of family, friends or others close to you that you **want** or **do not want** to be part of your medical discussions such as "I do not want _______________ to be part of my medical discussions." Or, "I would like _______________ and _______________ to be part of my medical discussions."

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☐ I chose to leave this section blank. (inital box)

Note: Please sign and date any additional pages you are attaching to this document.

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Part 3: My Hopes and Wishes

Note: This section is optional but helpful for your health care agent and family, friends or others who are involved in helping to make health care decisions for you at the end of your life.

☐ I chose to leave some of these questions blank. (inital box)

I want those involved in my health care and health care decisions to know my following thoughts and feelings:

1. The things that make life most worth living to me are (list things that get you up in the morning):

2. My beliefs about when life would no longer be worth living (list examples of situations in which living would be worse than dying):

3. My choices about specific medical treatments, if any (this could include your choices about ventilators, dialysis, antibiotics, tube feedings, hospice care or palliative care):

Hospice Care

Hospice care focuses on your comfort and quality of life when your health care provider believes you have 6 months or less to live.

Palliative Care

Palliative care is available if you are in any stage of advanced illness. It focuses on treating symptoms, emotional and spiritual concerns, and helps you and your family understand your illness and treatment choices.

Note: Please sign and date any additional pages you are attaching to this document.

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4. My hopes and wishes about how and where I would like to die:

5. If I am nearing my death, I would appreciate the following for comfort and support:

6. Share your thoughts and feelings about how the people caring for you can provide spiritual care that honors your cultural or faith traditions.

7. My religious affiliation:

I am of the ________________________ faith, and am a member of the ____________________ faith community in (city) ________________________________. Please try to notify them of my death and arrange for them to provide my funeral/memorial.

I prefer to be buried/cremated. (circle one)

I would like to include the following people, music, rituals, etc., if possible:

8. Other choices/instructions (this could include instructions about donating your body to science):

Note: Please sign and date any additional pages you are attaching to this document.

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Part 4: Making My Health Directive Valid

Under Minnesota law, you must sign and date this document in Minnesota in front of a notary public **or** two witnesses.

- Your notary or witnesses cannot be someone who is named as a health care agent in this document.
- Your notary cannot be a health care provider (but *can* be an employee of a health care provider) caring for you at the time you sign this document.
- If you sign before two witnesses, only one of the two witnesses can be a health care provider (or an employee of a health care provider) caring for you at the time you sign this document.

Important: Wait to sign your name until you are in front of either a notary public or two witnesses. The signature dates must match.

I have made this document willingly. I am thinking clearly. This document expresses my choices about my health care decisions:

Signature: ____ Date: ____________________

If I cannot sign my name, I ask the following person to sign for me:

Signature: ____

Print name: ____ Date: ____________________

The reason I cannot sign my name is: ____

Option 1: Notary public

In my presence on ____________ (date), ____________________________ (name of person completing this health care directive) 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. **I am not named as a health care agent or alternate health care agent in this document.**

> **Important**
>
> If you use a notary public, you do not need two witnesses.

County of: ____
(where document is signed)

Witness my hand and seal:

Notary signature: ____

Notary stamp:

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Option 2: Two witnesses

> **Important**
>
> If you use two witnesses, you do not need a notary public.

I declare that:

- this document was signed in my presence by the person completing this document or by an individual that the person completing this document authorized to sign on his or her behalf
- I am at least 18 years of age
- I am not named as a health care agent in this document.

Note: Only one of the two witnesses can be a health care provider (or an employee of a health care provider) caring for you at the time you sign this document.

Signature of Witness 1:

Signature: ______________________________ Date: ______________

Print name: ____

Address: ____

Are you a health care provider (or employee of a health care provider) giving direct care to the person creating this health care directive? ❑ yes ❑ no

Signature of Witness 2:

Signature: ______________________________ Date: ______________

Print name: ____

Address: ____

Are you a health care provider (or employee of a health care provider) giving direct care to the person creating this health care directive? ❑ yes ❑ no

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Part 5: Next Steps

Now that you have completed your health care directive, you have a few more steps to finish. <u>This page is not part of your health care directive.</u> You may separate it from the rest of the document and use it as a worksheet.

Checklist

- ❑ Keep the original copy of your health care directive where it can be easily found.
- ❑ Give a copy of your health care directive to your health care agent, health care provider(s) (so it can be scanned into your medical record) and those who may be involved in your health care or in helping to make health care decisions for you.
- ❑ Talk to anyone who may be involved if you have a serious illness or injury. Make sure they know who your health care agent is and understand your wishes, goals and values.
- ❑ If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be scanned into your medical record.
- ❑ Review, update or complete a new health care directive at least every 5 years or if:
  - — there is a major family change, such as divorce or death
  - — you are diagnosed with a serious health condition
  - — your health gets significantly worse, especially if you are unable to care for yourself or are unable to live on your own
  - — your health care agent is no longer willing or able.
- ❑ If your choices change, fill out a new health care directive and give new copies to your health care agent, health care provider(s), others who may be involved in your health care or in helping to make health care decisions for you and anyone who has copies of your old health care directive. Tell them what changed and to destroy any old copies.

Who has copies of this document

Give a copy of this document to your health care agent, health care provider(s), clergy, and those who may be involved in your health care or making health care decisions for you. Also take a copy of your health care directive with you when you go to the hospital or clinic for care.

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Allina Health advance care planning

- Allina Health has a secure, online health care directive that you can complete. Go to allinahealth.org/acp and sign up for a My Account with Allina Health.
- You can also attend a free class on how to fill out a health care directive. Check out the class listings at allinahealth.org/acp or call 612-262-2224 to get scheduled.

allinahealth.org

ALLINA HEALTH IS A TRADEMARK OF ALLINA HEALTH SYSTEM.
OTHER TRADEMARKS USED ARE OWNED BY THEIR RESPECTIVE OWNERS.
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