

Health Care Directives

Purpose of Form

Part I. Allows you to appoint another person (called a health care agent) to make health care Decisions for you if your attending physician decides that you lack decision-making capacity or you are unable to communicate your wishes, unless otherwise specified in the health care directive.

Part II. Allows you to give written instructions about what you want.

Part III. Requires you and others to sign and date to make this legal.

My personal information

My name: _____
Address: _____

Home phone: () _____ Work phone: () _____
Cell phone: () _____
Date of birth: _____
Social Security # _____

- I revoke all living wills, Durable Powers of Attorney for Health Care, or other written advanced health care directives I have signed in the past.

[NOTE: Make copies and use these Instructions to visit with Agents, Family and Physicians]

Part I: Naming an Agent

Agent Duties

My health care agent can:

- * Make health care decisions for me if my attending physician decides that I lack decision-making capacity or I am unable to communicate, unless otherwise specified in the health care directive.
- * Make decisions based on any instructions in Part II of this document or in other documents.
- * Make decisions based on what he or she knows about my wishes.
- * Act in my best interests if specific instructions are not available.

(If needed) Reason for naming health care provider

I have named as my agent a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed. That person is not related to me by blood, marriage, registered domestic partnership, or adoption. My reasons for wanting to appoint that person as my agent are: _____

My primary health care agent

I appoint:
 Agent's name: _____
 Address: _____

 Home phone: () _____ Work phone: () _____
 Cell phone: () _____
 Agent's name: _____
 Address: _____

 Home phone: () _____ Work phone: () _____
 Cell phone: () _____

My first alternate health care agent

My second alternate health care agent

(Optional)

Agent's name: _____
 Address: _____

 Home phone: () _____ Work phone: () _____
 Cell phone: () _____

Powers of my agent

If my attending physician decides that I lack decision-making capacity or I am unable to communicate my wishes, unless otherwise specified in the health care directive, my agent has the power to:

- * Consent to, refuse, or withdraw any health care, treatment, service or procedure
- * Stop or not start health care which is keeping or might be keeping me alive
- * Choose my health care providers
- * Choose where I live when I need health care and what personal security measures are needed to keep me safe
- * *Authority under HIPAA:* I intend for my Agent herein appointed to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. I grant to my Agent the power and authority to serve as my Personal Representative for all purposes under the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA"), 42 USC 1320d and 45 CFR 160-164.

Limiting the powers of my agent

I wish to limit the powers of my health care agent in the following ways:

Additional powers of my agent

If I want my agent to have any of the following powers, I must initial the line in front of the statement.

I also authorize my agent to:

_____ When I so delegate, make health care decisions for me even if I am able to decide or communicate for myself.

_____ Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics.

_____ In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions.

_____ Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in process or has been completed.

Part II: Health Care Instructions

I have completed the following Instructions – or, I am attaching Additional Instructions concerning my health care values and preferences to My Health Care Directives:

I want to be treated with dignity when making **End of Life or Health Care Choices**. As part of this Health Care Directives form, I am incorporating the following Instructions as a guide to my Agents and health Care Providers. I have strong feelings and beliefs about the quality of life I want to live. These beliefs effect my decisions for medical treatment and care when thinking about the end of life care issues or prolonging my life/my dying.

I. I understand **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 heart contract), medicines, electrical shocks, and a breathing tube. I understand that CPR can save a life. I also understand that it does not work as well for people who have chronic (long-term) diseases and/or impaired functioning. Therefore,

- I do not want CPR attempted if my heart or breathing stops, but rather, I want to permit a natural death.
- I want CPR attempted if my heart or breathing stops.
- I have requested my Doctor to sign a Do Not Resuscitate (DNR) Order.

Additional Instructions about this treatment: _____

II. I understand a **Ventilator/Respirator** to be a breathing machine used when I cannot breathe on my own. I understand that I cannot talk or eat by mouth when on this machine. Therefore,

- I want a Ventilator/Respirator used.
- I want a Ventilator/Respirator used for an acute crisis to help me breathe.
- I do not want a Ventilator/Respirator used.
- I have requested my Doctor to sign a Do Not Intubate (DNI) Order.

Additional Instructions about this treatment: _____

III. I understand **Nutritional Support and Hydration** mean that when I cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support my existence indefinitely. I realize that this treatment may involve putting a tube into my stomach, through my nose, into my intestine or into my veins. Therefore,

- I want Nutritional Support and Hydration.
- I want Nutritional Support and Hydration Procedures used in an acute crisis.
- I do not want Nutritional Support and Hydration Procedures used.

Additional Instructions about this treatment: _____

IV. I understand **Dialysis** to mean that a machine would be used to clean my blood when my kidneys are not working well. I understand that I may die sooner if this procedure is needed and is not done. Therefore,

- I want Dialysis done for me.
- I want Dialysis done in acute situations.
- I do not want Dialysis.

Additional Instructions about this treatment: _____

V. I understand that **Blood Transfusions / Blood Products** may be used during surgery or as treatment for some diseases. Therefore,

- I want Blood Transfusions / Blood Products.
- I want Blood Transfusions / Blood Products used in an acute crisis.
- I do not want Blood Transfusions / Blood Products.

Additional Instructions about this treatment: _____

VI. I know that **Antibiotics** are used to treat infections and can be viewed as prolonging life support. Therefore,

- I want Antibiotics used.
- I want Antibiotics used in an acute crisis.
- I do not want Antibiotics used.

Additional Instructions about this treatment: _____

VII. **Pain Management.** I want to be kept comfortable and as free of pain as possible. Therefore,

- Even if it means that I may not interact very well with people, I want Pain Management.
- Even if it means that my ability to think clearly might be diminished, I want Pain Management.
- Even if it means that my time of life and dying could be shortened, I want Pain Management.
- I want my Doctor to prescribe enough medication to relieve my pain.
- I want to have radiation treatment only if intended to relieve pain.

Additional Instructions about this treatment: _____

VIII. Other **Final Wishes.**

- I authorize donation of my organs, tissues, and other body parts after my death.
 - Yes
 - No

Additional Final Wishes: _____

Remember to have discussions about these instructions with your agents, family and physician.

Also pre-arrange your funeral and burial decisions.

Part III: Making This Document Legal

**My
Signature/
mark and
date**

I agree with everything in this document and have made this document willingly:
My signature: _____
Date: _____
(month / day / year)

Either Notary Public or Witnesses

**Notary
Public**

NOTE: Must not be named as agent or alternate agent.

STATE OF MINNESOTA
COUNTY OF _____
This document was signed or acknowledged before me this _____ day of _____, _____ by the above named principal.
(month) (year)

Signature of Notary Public
(Stamp)

OR

**Two
Witnesses**

Note: Only one witness can be a direct care provider or employee of a provider on the day this is signed.

This document was signed or acknowledge in my presence. I am not an agent or alternate agent in this document.
Witness Signature: _____
Address: _____
Date: _____
(month / day / year)
Witness Signature: _____
Address: _____
Date: _____
(month / day / year)

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