Minnesota
Health Care Directive

Parts of this form

- **Part I: Naming an Agent** (required)
- **Part II: Health Care Instructions** (optional)
- **Part II Addendum: Health Care Instructions Worksheet** (optional)
- **Part III: Making this Document Legal** (required)

My personal Information

My legal name: _____

Address: _____

_____

Home phone: _____

Work phone: _____

Date of birth: _____

PART I: NAMING AN AGENT

(required)

Agent duties

My health care agent can:

- Make health care decisions for me if I am unable to make and communicate decisions for myself.
- 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 instructions are not available.

Agent roles

When naming my health care agent, I must choose one of the following:

Initial the line in front of the statement you WANT.

_____ I appoint **one person** to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each **alternative agent** I name my act alone, in the order listed.

_____ I appoint **two or more persons to act together** as my health care agent. My primary agent **and** alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.

PART I: NAMING AN AGENT (continued)

(required)

My primary health care Agent

I appoint:
Primary agent's name: _____
Address: _____
_____
Home phone: _____
Work phone: _____

My first alternative health care agent

1st alternative agent's name: _____
Address: _____
_____
Home phone: _____
Work phone**:** _____

My second alternate health care agent

2nd alternative agent's name: _____
Address: _____
_____
Home phone: _____
Work phone: _____

Reasons for naming health care provider *(if needed)*

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: _____
_____
_____
_____

Powers of my agent

If I am unable to decide or speak for myself, 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 keep 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
- Obtain copies of my medical records and allow others to see them

PART I: NAMING AN AGENT (continued)

(required)

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 below.

I also authorize my agent to:

_____ Make health care decisions for me even if I am able to decide or speak for myself.

_____ Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die.

_____ 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.

Limiting the powers of my agent

I wish to limit the powers of my health care agent in the following way(s):

_____

_____

PART II: HEALTH CARE INSTRUCTIONS

(optional)

I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments or situations):

_____

_____

Initial one line:

I am attaching additional instructions concerning my health care values and preferences on a separate, attached document. _____ Yes _____ No

Initial the lines that apply to you.

_____ **Yes**, I want to donate organs, tissue, or other body parts when I die.

_____ Any needed organs, tissue, or other body parts

_____ Only the following organs, tissue, or other body parts: _____

Limitations or special wishes I have include: _____

_____ **No**, I do not want to donate organs, tissue, or other body parts when I die.

PART II Addendum:
HEALTH CARE INSTRUCTIONS WORKSHEET

(optional)

Having a sense of what is important to you can help your agents make health care decisions under complex circumstances. Read each statement below and rate how important each of the health care goals are to you. Remember, medical care should always include maintaining a person's comfort, hygiene, and human dignity.

HEALTH CARE GOALS	Not Important		Somewhat Important		Extremely Important
	0	**1**	**2**	**3**	**4**
How important is pain control?					
Being as comfortable and free from pain as possible					
Having pain controlled, even if my ability to think clearly is reduced					
Having pain controlled, even if it shortens my life					
How important is the use of life prolonging treatment when:					
I have a reasonable chance of recovering both physically and mentally					
I have some physical limitations but can socially relate to those I care about					
I can live a longer life no matter what my physical or mental health					
I have little or no chance of doing everyday activities I enjoy					
I am not able to socially relate to those I care about					
I have a terminal illness and treatment will only prolong when I die					
I have severe and permanent brain injury and there is little chance of regaining consciousness					
I have severe dementia or confusion and my condition will only get worse					
Important of finances and health care					
Having my wishes followed regardless of whether or not my finances are exhausted					
Not being a financial burden to those around me					
Not having my health care costs affect the financial situations of those I care about					

I also want my decision makers to know the following things are important to me when receiving health care:

PART II Addendum:
HEALTH CARE INSTRUCTIONS WORKSHEET (continued)

(optional)

My medical treatment preferences

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a health care professional to make sure you understand what they might mean for you given your current as well as future health conditions.

Medical procedure	**When it is used and its effects**	**My feelings about this procedure**
Ventilator / respirator (breathing machine) A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure	When you cannot breathe on your own You cannot talk or eat by mouth on this machine	
Nutrition support and hydration	When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely. Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins.	
Cardiopulmonary Resuscitation (CPR) A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.	Actions to make your heart and lungs start if they stop, including pounding on your chest, electric shocks, medications, and a tube in your throat.	
Dialysis	A mechanical means of cleaning the blood when your kidneys are not working.	

PART II Addendum:
HEALTH CARE INSTRUCTIONS WORKSHEET (continued)

(optional)

My feelings or concerns about other medical treatments include: _____

_____

_____

If I am pregnant, my feelings about medical treatment would include: _____

_____

_____

My religious and spiritual beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying, and when they have died.

My decision makers should know the following about how my religious or spiritual beliefs should affect my health care: _____

_____

_____

My religion / spirituality is: _____

My congregation / spiritual community is (name, city, state): _____

_____

I wish to have my priest / pastor / rabbi / shaman / spiritual leader consulted. *(circle)* Yes No

If yes, the person to be contacted is (name, phone number): _____

_____

Feelings about quality and length of life

I have the following beliefs about whether life should be preserved as long as possible: _____

_____

The following kinds of mental or physical conditions would make me think that medical treatment should no longer keep me alive: _____

_____

PART II Addendum:
HEALTH CARE INSTRUCTIONS WORKSHEET (continued)

(optional)

My preferences for care when dying

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

_____ At home _____

_____ At a hospital. Which one? _____

_____ At a nursing home. Which one? _____

_____ Through hospice services. Which one? _____

_____ From other health care providers. Which ones? _____

Other wishes I have about my care when I am dying: _____

_____

Additional health care instructions

My agents should also know these things about me to help them make decisions about my health care: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PART III: MAKING THIS DOCUMENT LEGAL

(required)

My signature and date signed

I agree with everything in this document and have made this document willingly. I revoke all living wills, durable powers of attorney for health care, or other written advance health care directives I have signed in the past.

My printed name: _____

My signature: _____

Date signed (month/day/year): _____

This document must be signed by two witnesses OR one notary public.

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

Two witnesses

This document was signed or acknowledged in my presence.
I am <u>not</u> an agent or alternate agent in this document.
Witness #1 printed name: _____

Witness #1 signature: _____

Date signed (month/day/year): _____

This document was signed or acknowledged in my presence.
I am <u>not</u> an agent or alternate agent in this document.
Witness #2 printed name: _____

Witness #2 signature: _____

Date signed (month/day/year): _____

NOTE: **The notary public must <u>not</u> be named as an agent or alternate agent.**

Notary Public

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

Notary signature: _____