Honoring Choices® MINNESOTA

Health Care Directive English

Meets legal requirements for Minnesota and Wisconsin residents

Introduction

I have created this document with much thought to give my treatment choices and personal preferences if I cannot communicate my wishes or make my own health care decisions. I have also appointed a health care agent to speak for me. My agent is able to make medical decisions for me, including the decision to decline treatments that I do not want. Any document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

My telephone number: _____ My cell number: _____

Part 1: My Health Care Agent

If I am unable to communicate my wishes and health care decisions due to illness or injury, or if my health care providers have determined that I am not able to make my own health care decisions, I appoint the following person(s) to represent my wishes and make my health care decisions*, including the decision to decline treatments I do not want. When choosing a health care agent I have considered his/her ability to willingly make decisions while being aware of my treatment choices. This person can follow my wishes under times of stress.

My primary (main) health care agent is:

Name: _____Relationship: _____

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

Address: _____

* *I understand that my agent cannot be a health care provider or employee of a health care provider giving direct care to me or their spouse, unless I am related to that person by blood or marriage, registered domestic partnership, or*

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Name_____
Date_____

*adoption. If my agent is a health care provider or an employee of a health care provider, my reason for choosing him or her is:*_____

_____

_____

If I cancel my primary agent's authority, or if my primary agent is not willing, able, or reasonably available to make a health care decision for me, I name as my alternate agent:

Alternate health care agent:

Name: _____Relationship:_____

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

Address: _____

Powers of my health care agent:

My health care agent automatically has all the following powers when I am unable to speak for myself:

- ☐ Make choices for me about my medical care. This includes taking out or not putting in tube feedings, tests, medicine, surgery and decisions of treatments if I am pregnant and all types of mental health treatment, including intrusive mental health treatments or medications. If treatment has already begun, my agent can continue it or stop it based on my instructions.
- ☐ Interpret any instruction I have given in this form according to his or her understanding of my wishes, values and beliefs.
- ☐ Review and release my medical records and personal files as needed for my medical care.
- ☐ Arrange for my medical care and treatment in Minnesota or any other state or location he or she thinks is appropriate. This includes nursing homes and community-based residential facilities.
- ☐ Decide which health providers and organizations provide my medical treatment.

Comments or restrictions on the above (e.g., persons you would or would not want to be involved in making decisions on your behalf or limitations on the above powers for your agent):

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Name_____
Date_____

Additional powers of my health care agent: *(If I want my agent to have any of the following powers, I will check the box in front of each statement below)*

☐ Arrange for and make decisions about the care of my body after death.

☐ 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.

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

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Name_____

Date_____

This page is required for Wisconsin residents only.

Power of Attorney for Healthcare Document

Notice to the Person Making This Document:

You have the right to make decisions about your healthcare. No healthcare may be given to you over your objection, and necessary healthcare may not be stopped or withheld if you object.

Because your healthcare providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your healthcare.

In order to avoid this problem, you may sign this legal document to specify a person who you would want to make healthcare decisions for you if you become unable to make those decisions personally. That person is known as your healthcare agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons you might specify. You may state in this document any types of healthcare that you do or do not desire, and you may limit the authority of your healthcare agent. If your healthcare agent is unaware of your desires with respect to a particular healthcare decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make healthcare decisions for you. It revokes any prior power of attorney for healthcare that you may have made. If you wish to change your Power of Attorney for Healthcare, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses.

If you revoke, you should notify your agent, your healthcare providers and any other person to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced after signing this document, the designation of your spouse as healthcare agent shall no longer be valid.

You may also use this document to make or refuse to make any anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift you may have made. You may revoke or change any anatomical gift that you make in this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it.

It is suggested that you keep the original of this document on file with your physician.

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Name_____
Date_____

Part 2: My Health Care Directives

My choices and preferences for my health care are as follows. I ask my agent to represent them, and my doctors (and/or health care team) to honor them, should I become unable to make my own health care decisions or communicate my wishes. ***I have checked the box below for the option I prefer for each circumstance.***

Note: You do not need to provide written instructions about treatments to extend your life, but it is helpful to do so. If you choose not to, your health care agent will make decisions based on your spoken directions or on what is considered to be in your best interest.

1. Treatments to prolong my life:

If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to know who I am (For Wisconsin residents, if I have a terminal condition or am in a persistent vegetative state):

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

or

☐ **I *do* want** all appropriate treatments recommended by my doctor, until my doctor and agent agree that such treatments are harmful or no longer helpful.

Comments or directions to health care providers:

_____

_____

_____

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

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Name_____

Date_____

2. **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. I understand that recovery from CPR can be painful and difficult. Therefore:

☐ I do not want CPR attempted if my heart or breathing stops, but rather, want to permit a natural death.

or

☐ I want CPR attempted unless my doctor determines any of the following:

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

or

☐ I want CPR attempted if my heart or breathing stops.

3. **Treatment Preferences.**

☐ I have attached treatment preferences for my specific health condition(s). These statements describe my treatment choices. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as foods and fluids by mouth if I am able to swallow.

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Name_____
Date_____

Part 3: My Hopes and Wishes (Optional)

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

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

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

3. My choices about specific medical treatments, if any (this could include your wishes regarding ventilators, dialysis, antibiotics, tube feedings etc.):

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

5. 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.):

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

7. Organ donation (leave blank if you have no preference).

☐ **I do want** to donate my eyes, tissues and/or organs, if able. My specific wishes (if any) are:

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

8. Other wishes/instructions:

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Name_____
Date_____

Part 4: Legal Authority

Under Minnesota law, you must have this document signed and dated in the presence of two witnesses or a notary public. **Wisconsin residents must have this document signed and dated in front of two witnesses. (Social workers and chaplains are the only health care providers who can witness in Wisconsin.)**

I have made this document willingly, I am thinking clearly, and this document expresses 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: _____

Signature (of person asked to sign): _____

Statement of Witnesses:
I personally witnessed the signing of this document, and I certify that I am not appointed as a 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: _____. At least one witness cannot be a provider or an employee of the provider giving direct care on the day this document is signed. **Wisconsin witnesses cannot be related to the person listed above by blood, marriage, adoption or domestic partnership, cannot have a claim on the person's estate or be directly financially responsible for their health care.**

Witness Number One:
Signature_____ Date: _____
Print name _____
Address _____

Witness Number Two:
Signature _____ Date:_____
Print name _____
Address _____

or

Notary Public:
In my presence on _____ (date), _____ (name) 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 in this document.
Signature of notary: _____
Notary stamp:

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Name_____
Date_____

Part 5: Next Steps

Now that you have completed your health care directive, you should also take the following steps.

- Tell the person you named as your health care agent, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future.
- Give your health care agent a copy of your health care directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.
- Give a copy of your health care directive to your doctor. Make sure your wishes are understood and will be followed.
- Keep a copy of your health care directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any of the "Five D's" occur:

  Decade – when you start each new decade of your life.

  Death – whenever you experience the death of a loved one.

  Divorce – when you experience a divorce or other major family change.

  Diagnosis – when you are diagnosed with a serious health condition.

  Decline – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

Copies of this document have been given to:

Primary (Main) Health Care Agent Name: _____
Telephone: _____ Cell: _____

Alternate Health Care Agent Name: _____
Telephone: _____ Cell: _____

Health Care Provider/Clinic
Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

If your wishes change, fill out a new health care directive form and tell your agent, your family, your doctor, and everyone who has copies of your old health care directive forms.

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Name_____
Date_____