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THE MINNESOTA HEALTH CARE DIRECTIVE

M I N N E S O T A

H E A L T H C A R E D I R E C T I V E

Purpose of This Form

I, _____, understand this document allows me to complete Part I, Part II, or both. I must complete Part III for this document to be legal.

Part I Naming a Health Care Agent

I can name another person (called my Health Care Agent) to make health care decisions for me if a doctor determines that I am unable to do so. My agent must make decisions based upon any instructions I provide in this document or in my best interest, if I have written no instructions.

Part II Health Care Instructions

I can provide health care instructions about what I do and do not want for my health care. These instructions are to be used by my agent, if I have named one. They may also be used by my family, health care providers, or others assisting in my health care.

Part III Legalizing the Document

I sign this section with two witnesses or a notary.

Personal Information

My Name: _____

Address: _____

_____

Phone #: (_____) _____

Date of Birth: _____

Revocation of Past Documents

By initialing after this line, I revoke all living wills, Powers of Attorney for Health Care or other written advance health care directives I have made in the past:_____

PART I NAMING A HEALTH CARE AGENT

THIS IS THE PERSON I WANT TO MAKE HEALTH CARE DECISIONS
FOR ME IF I AM UNABLE TO SPEAK FOR MYSELF.

My Primary Health Care Agent

I appoint the following person to be my primary Health Care Agent:

Agent's Name: _____

Address: _____

_____

Home Phone: (____) _____

Alternate Phone: (____) _____

My Alternate Health Care Agent

If my primary Health Care Agent is not reasonably available to make my health care decisions, I appoint this person to be my Health Care Agent instead:

Agent's Name: _____

Address: _____

_____

Home Phone: (____) _____

Alternate Phone: (____) _____

Reasons For Naming Health Care Provider As Agent

IF the person named as a primary or alternate Health Care Agent is a health care provider or an employee of a health care provider who is caring for me:

I can state reasons for wanting this person to be my agent here:

_____

_____

Automatic Powers of My Agent

My Health Care Agent is Automatically Given the Four Powers Listed Below:

- To make health care decisions for me if I am unable to make those decisions or communicate them.
- To choose my health care provider(s).
- To choose where I live and receive health care and supports related to my health care.
- To review my medical records and have the same rights as I would have to release my records to others.

Optional Powers of My Agent

My Health Care Agent will have the following powers ONLY if I have initialed next to the power:

_____ To decide whether to donate my organs when I die.

_____ To decide what will happen with my body when I die (burial, cremation, etc.).

_____ To make health care decisions for me EVEN IF I am able to decide or speak for myself.

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

_____ If married or in a domestic partnership, to continue authority of my proxy even if we become divorced, legally separated, our marriage is annulled, or we are no longer domestic partners.

Limits on My Agent's Powers

If I want to limit any of the automatic powers of my agent, or place limits on what my agent may do regarding my health care, I will write them here:

_____

_____

_____

Notice of Health Care Instructions

I am also completing Health Care Instructions: _____ YES _____ NO

PART II HEALTH CARE INSTRUCTIONS

THESE ARE MY INSTRUCTIONS FOR MY HEALTH CARE WHEN I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF.

A. My General Views Regarding My Health Care

If I had a reasonable chance of recovery both physically and mentally, I would want:

_____

_____

If I had severe dementia or confusion I would want:

_____

_____

If I were permanently unconscious, I would want:

_____

_____

If I were dying, I would want:

_____

_____

My opinions about pain relief if it would affect my ability to think clearly or if it could shorten my life:

_____

_____

My opinions about my own and my family's finances with regard to my health care:

_____

_____

_____

_____

B. My Views Regarding Specific Medical Treatments

My opinions about a ventilator / respirator - OR - a Do Not Intubate order (DNI) IF I cannot breathe on my own:

_____

_____

My opinions about artificial nutrition and/or hydration if cannot eat or drink on my own:

_____

_____

My opinions about CPR (cardiopulmonary resuscitation) - OR - a Do Not Resuscitate (DNR) order to restart my heart or lungs, if they stop:

_____

_____

My opinions about dialysis if my kidneys stop working:

_____

_____

My opinions about any other medical treatments:

_____

_____

My opinions about what kind(s) of physical or mental conditions make me think that medical treatment should no longer be used to keep me alive:

_____

_____

_____

_____

_____

C. My Religious and Spiritual Beliefs

If I have religious and spiritual beliefs which my agent or health care providers should know regarding my health care, I will list them here:

_____

_____

My religion / spirituality and congregation / spiritual community:

_____

_____

If I would like a spiritual advisor / leader consulted, I will list that person here:

_____

_____

D. My Preferences for Health Care When I Am Dying

If possible while I am dying, I would like to receive care:

_____ At home: _____

_____ At this hospital: _____

_____ At this nursing home: _____

_____ With hospice services by: _____

_____ With other health care providers: _____

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

_____

_____

_____

_____

_____

E. My Wishes Regarding Donation of Organs, Tissues, or Other Body Parts

_____ I DO NOT want any of my organs, tissues, or body parts donated after my death.

_____ I DO wish to donate organs, tissues, or body parts after my death.

_____ Any needed organs, tissues, or other body parts

_____ Only the following:

_____

_____

F. My Wishes Regarding What Happens to My Body After I Die

The following are my wishes regarding what happens to my body after I die:

_____

_____

_____

_____

_____

_____

G. Notice of Appointment of Health Care Agent

I have also appointed a Health Care Agent: _____ YES _____ NO

_____

_____

PART III MAKING THE DOCUMENT LEGAL

REQUIREMENTS: A. My signature - or - the signature of the person I authorize to sign on my behalf.

B. Either:

1. Verification by a notary public,

Or:

2. Witnessing by two witnesses.

A. My Signature:

I am thinking clearly. I agree with everything that is written in this document. I have completed this document willingly.

My signature:_____

Date completed:_____

I am unable to sign my name and have authorized this person to sign for me:

Signature of the person I have authorized:_____

Printed name of the person I have authorized:_____

Date signed:_____

B. Option 1: Notary Public

State of Minnesota County of:_____

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

_____

(Signature of Notary) (Notary Stamp)

B. Option 2: Two Witnesses

Two witnesses must sign.

Only one of the two witnesses can be a health care provider or an employee of a health care provider currently providing care to me.

Any person named as a Health Care Agent or Alternate Health Care Agent may not act as a witness.

Each witness must be least 18 years of age.

Witness One:

This document was signed or acknowledged in my presence. I am not named as a Health Care Agent or Alternate Health Care Agent in this document.

Witness One Signature:_____

Address: _____

_____

Date:_____

Witness Two:

This document was signed or acknowledged in my presence. I am not named as a Health Care Agent or Alternate Health Care Agent in this document.

Witness Two Signature:_____

Address: _____

_____

Date:_____

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, family, close friends, Health Care Agent and Alternate Agent. Make sure your doctor is aware of your wishes and willing to follow them. A copy of this document should be a part of your medical records at your doctor's office, at the hospital, and with any home care, hospice, or nursing facility providing care to you.

Updated 6/4/2013