712246AD

My Health Care Directive

The Park Nicollet Health Services Advance Care Planning and Patient Preferences Document

Purpose of the Health Care Directive:

Part 1—My Health Care Agent
Allows you to appoint another person (called a health care agent) to make health care decisions if you are unable to do so. Health care agents must be 18 years or older.

Part 2—My Health Care Directives
Allows you to give written instructions about what you want.

Part 3—My Hopes and Wishes *(optional)*
Allows you to make your wishes known to your designated agent(s).

Part 4—Legal Authority
Requires you and others to sign and date to make this document legal. Witnesses must be 18 years or older.

Part 5—Next Steps
Provides you with advice on next steps that you might want to consider.

12246 (7/2009)

Park Nicollet

NAME:

DOB:

MR#: HCL# :

LABEL or ADDRESSOGRAPH

Honoring Choices Minnesota Health Care Directive

Introduction

I have created this document with much thought to give my treatment choices and personal preferences if I cannot communicate my wishes. 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. I am:

My name: _____

My date of birth: _____

My address: _____ **ZIP:** _____

My telephone number: _____ **My cell:** _____

Copies of this document have been given to:

Primary (Main) Health Care Agent:

1. _____ Telephone: _____ Cell: _____

First Alternate Health Care Agent:

2. _____ Telephone: _____ Cell: _____

Health Care Provider/Clinic:

3. _____ Telephone: _____ Cell: _____

4. _____ Telephone: _____ Cell: _____

5. _____ Telephone: _____ Cell: _____

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 understand my situation, I appoint the following person(s) to represent my wishes and make my health care decisions*. 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: _____ ZIP _____

If I revoke my agent's authority or if my 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: _____ ZIP _____

I want my health care agent to:

- make choices for me about my medical care. This includes tests, medicine and surgery. If treatment has already begun, my agent can either 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.
- decide which health providers and organizations provide my medical treatment.

Comments or restrictions on the above:

_____

_____

_____

* *I understand that my agent cannot be a health care provider or employee of a health care provider giving direct care to me unless I am related to that person by blood or marriage, registered domestic partnership, or adoption, or provide a clear reason why I want that person to serve as my agent. If my agent is a health care provider or an employee of a health care provider, my reason for choosing him or her is:* _____

_____

_____

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 communicate my wishes. ***I have initialed below 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 your 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 interact meaningfully:

   _____ 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.

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.

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:

Part 3: My Hopes and Wishes *(optional)* continued

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:

_____

_____

_____

_____

_____

_____

_____

_____

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.

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.

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:

Part 5: Next Steps

Now that you have completed your advance directive, you should also **take the following steps**. This page is not part of your advance directive: you may separate it from the rest of the document and use it as a worksheet.

- 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 examination and 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.

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