

# *Minnesota Health Care Directive*

## *The right to control your health care decisions*

*Planning for and managing your health care needs is a difficult yet very important task. Completing a health care directive will help to inform health care professionals and those important to you about your wishes as it relates to health care decision making. You have the right to appoint an alternate decision maker (agent) to make decisions for you when you are either unable to participate in health care decision making or you choose not to participate in your health care decision making.*

*You can help your alternate decision maker and health care professionals to better know your wishes by completing the health care instructions section of this booklet. This section allows you to express your wishes for the type of medical care and treatment that you would want or not want.*

*Taking the time to map out your health care plan is a powerful step. You can rest easy, knowing that your health care providers and those important to you understand your medical wishes.*



200 STATE AVENUE • FARIBAULT, MN 55021 • 507.334.6451

# Questions & answers about informing others of your health care wishes

*Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury. The information in this booklet provides general information about health care directives and how to prepare them.*

## **What is a health care directive?**

A health care directive is a written document that informs others of your wishes about your health care. It allows you to name a person (“agent”) to make decisions for you if you are unable or unwilling to do so. You must be at least 18 years old to make a health care directive.

## **Why have a health care directive?**

Putting your wishes in writing is the best way to help make sure your wishes will be known and followed by family, friends, health care providers and others.

## **Must I have a health care directive?**

You are not required to have a health care directive. But writing a directive helps to make sure your wishes are followed.

## **What happens if I don't have one?**

You will still receive medical treatment without a written directive. Health care providers will listen to those close to you about your treatment preferences. But the best way to be sure your wishes are followed is to have a health care directive.

## **How do I create a health care directive?**

There are forms for health care directives. You don't have to use a form, and you don't need an attorney to assist you. Your health care directive must meet the following requirements to be legal:

- Be in writing
- Be dated
- State your name
- Be created by a person with the capacity to do so
- Be signed by you or someone authorized by you to sign on their behalf
- Contain verification of your signature (or authorized signer) by either a notary public or two witnesses
- Include health care instructions, a health care power of attorney, or both

Before you finalize your directive, it is best to discuss your health care wishes with your doctor or other health care provider.

## **When does my healthcare directive become effective?**

Your healthcare directive becomes effective when your attending physician determines that you lack the decision-making capacity to make the health care decision, or if other conditions that you have specified within your directive are met.

Your healthcare directive is not effective when your attending physician determines that you have recovered your decision-making capacity.

### **If I name a healthcare agent, do I give up the right to make my own decisions about my health care?**

Naming a healthcare agent does not automatically give that person authority to act on your behalf or to have access to your medical record information. An agent has no legal authority until your attending physician determines that you lack the decision making capacity for your health care. You may also choose to have your healthcare agent assume the role of decision maker. Your decision making authority is situational and should be rechecked at every significant decision point.

### **What can I put in my healthcare directive?**

You have many choices of what to put in your health care directive. For example, you may include:

- The person or persons you want to act as your health care agent(s)
- Instructions for your agents(s) about how you want them to decide, including a statement whether joint agents may decide independently of one another
- Any limitations to the decision making authority of your healthcare agent(s)
- Any limitations to your agent in the case of a dissolution or annulment of marriage or termination of domestic partnership
- If choosing a health care provider or employee of a health care provider, specific

reasons for this appointment

- Any limitation on the nomination of your healthcare agent to be appointed as your guardian if court action is necessary
- Your goals, values and preferences about health care (including where you would prefer to receive your care)
- Health care instructions regarding artificially administered nutrition or hydration
- Instructions regarding mental health care and treatment
- Health care instructions if you are pregnant and how you would want this to affect health care decision making
- Donation of organ, tissues, or eyes or arrangements for anatomical gifts
- Funeral arrangements

### **Are there any limits to what I can put in my health care directive?**

There are some limits about what you can put in your health care directive. For instance:

- Your agent must be at least 18 years of age.
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for naming your provider in your directive.
- You cannot request health care treatment that is outside of reasonable medical practice.
- You cannot request assisted suicide.

**What if I've already prepared a health care directive? Is it still good? How can I make changes or cancel it?**

A health care directive is valid as long as it met the requirements of the law when it was written. It is recommended that you review your document on a regular basis to assure that it still reflects your wishes about your health care. If significant changes are needed to your document, you may want to complete a new document. Be sure to provide updated/new copies to those who already have a copy of your existing directive. If you wish to cancel your existing directive, you may do so by destroying your document and notifying, in writing, anyone who has a copy of your directive.

**I prepared my directive in another state. Is it still good?**

A health care directive prepared in another state is legal if it meets the requirements of that state's laws or the Minnesota requirements. Requests for assisted suicide cannot be followed in Minnesota.

**What if my health care provider refuses to follow my health care directive?**

Your health care provider must follow your health care directive, or any instructions from your agent, as long as the health care follows reasonable medical practice. However, you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in

your medical record. The provider must allow the agent to arrange to transfer you to another provider who will follow the agent's directions.

**What should I do with my health care directive after I have signed it?**

You need to inform family members, your health care agent or agents, and your health care provider that you have a health care directive. You should give them a copy. It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found. Don't store it in a safe deposit box.

**What if I have concerns or questions about difficult or ethical issues concerning my health care?**

Please ask your physician, nurse, or social worker how to access the Faribault Area Ethics Committee for case consultation.

*If you would like more information, please contact District One Hospital Social Services at 507.332.4890. You may also contact your health care provider, your attorney or the Minnesota Board of Aging's Senior Linkage Line at 800.333.2433.*

# Minnesota Health Care Directive

**My information:** (please print)

My full name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Work phone \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security number \_\_\_\_-\_\_\_\_-\_\_\_\_ (optional)

**My primary health care provider:**

Physician \_\_\_\_\_

Clinic/practice group \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

**My preferred health care facility:**

Hospital \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

*By completing and signing this document, you are revoking all living wills, Durable Powers of Attorney for Health Care, or other written advance health care directives you have signed in the past.*



200 STATE AVENUE • FARIBAULT, MN 55021 • 507.334.6451

*If you don't wish to appoint a health care agent, you may leave Part 1 blank and go to Part 2.*

**BEFORE** naming an agent or alternate agent, talk with each to be sure he or she is willing to:

- serve as your agent
- take time to talk with you to understand your wishes
- follow your instructions and act in your best interest
- be contacted and willing and able to act in a timely manner

*You cannot appoint as agent a health care provider or employee of a provider giving direct care to you unless:*

- he or she is related by blood or marriage, or
- you state specifically why you want him or her.

*Your **health care agents** (primary and alternate) must be over the age of 18.*

## Part 1: Naming an Agent

Allows you to appoint a person (called an agent) to make healthcare decisions if a doctor decides you are unable to do so or if you choose to have an agent speak for you.

When I am unable to decide or communicate for myself, I trust and appoint as my **primary health care agent**:

### Primary Health Care Agent

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Relationship to me)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Cell Phone)

If my primary agent is a healthcare provider or employee of a healthcare provider, this is why I've selected this person: \_\_\_\_\_

If my primary health care agent is not available, I trust and appoint as my **alternate health care agents**:

### Alternate Agent 1

### Alternate Agent 2

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship to me)

\_\_\_\_\_  
(Relationship to me)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Cell Phone)

\_\_\_\_\_  
(Cell Phone)

I wish my agent(s) to make decisions in the following manner: (initial one)

\_\_\_\_\_ My primary agent may act alone. If my primary agent is unable or unavailable, my alternate agent may act alone.

\_\_\_\_\_ I appoint my primary agent and alternate agent(s) to work together and be in agreement for decision making.

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ In the event of my marriage dissolution, annulment or termination of domestic partnership, I wish my spouse to continue as my health care agent. (Please initial in the blank if so desired.)

# Power of Health Care Agents

Your health care agent is automatically given the powers listed in A through D.

Whenever I am unable to, or choose not to, decide or speak for myself, my health care agent has the power to:

- A. Make any health care decision for me. This includes the power to give, refuse or withdraw consent to any care, treatment, service or procedures. This includes deciding whether to stop or not start health care which is keeping me or might keep me alive. *Regarding mental health treatment*, my agent(s) has the power to make decisions relating to intrusive mental health treatment.
- B. Choose my health care providers.
- C. Choose where I receive care and support when those choices relate to my health care needs.
- D. Review my medical records and decide who else might need to review my records.

If I **do not** want my health care agent to have a power listed above in **A** through **D** OR if I want to **limit** any power in **A** through **D**, I **must** say that here:

---

---

---

---

## Additional Powers

If I **want** my agent to have any of the powers listed in 1 through 4, I must **initial** the line in front of the power; then my agent **will have** that power.

- \_\_\_\_\_ 1) To decide whether to donate any parts of my body, including organs, tissues and eyes when I die. (See page 6.)
- \_\_\_\_\_ 2) To decide what will happen with my body when I die (burial, cremation, anatomical donation).
- \_\_\_\_\_ 3) In the event I am pregnant, to determine whether all efforts should be made to continue my pregnancy to delivery based upon understanding my values, preferences or instructions.
- \_\_\_\_\_ 4) Determine who may visit me. This includes restricting visitors when appropriate or necessary.

If I want to say anything more about my health care agent's powers or limits of power, I can say it here: \_\_\_\_\_

---

---

*Your health care agent must follow your health care instructions in this document or any other instructions you have given to your agent. If you have not provided health care instructions, then your agent must act in your best interest.*

*Intrusive mental health treatment can include electroconvulsive therapy (ECT) and neuroleptic medications.*

*Your health care agent is not automatically given the powers listed in 1 through 3.*

*Complete Part 2 if you wish to give health care instructions. If you appointed an agent in Part 1, completing Part 2 is optional but would be very helpful to your agent. However, if you choose not to appoint an agent in Part 1, you must complete some or all of Part 2 if you wish to make a valid health care directive. In either case, you must complete Part 3 for the directive to be valid.*

## Part 2: Health Care Instructions

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs.)

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 anticipated, health conditions.

### Thoughts to consider:

- How do you want to be cared for in the event of an acute event such as a car accident, heart attack, etc.
- How do you want to be cared for in the event of a terminal illness?
- What does “quality of life” mean to you?
- Is life worth living if you had to be sustained by a respirator?
- Do you believe that food and water are a medical treatment or basic necessity?

Medical Procedure	Purpose & Explanation	My <u>Feelings</u> About This Procedure
Cardiopulmonary Resuscitation (CPR)  A Do Not Resuscitate (DNR) order is put on your medical record when you <b>don't</b> want this procedure.	Actions to make your heart and lungs start if they stop. This includes chest compressions, electric shocks, medications and a tube in your throat.	
Nutrition support and hydration	When you can't eat or drink by mouth, feeding solutions can provide enough nutrition to support life. Feeding solutions can be put through a tube in your stomach, nose, intestine or veins.	
Ventilator or Respirator (a breathing machine)  A Do Not Intubate (DNI) order is put on your medical record when you <b>don't</b> want this procedure	When you cannot breathe on your own, a tube is inserted down your throat and a machine breathes for you. You can't talk or eat by mouth on this machine.	
Dialysis	A mechanical means of cleaning the blood when kidneys aren't working.	
Blood transfusions	Receiving components of human blood to provide multi-system stability.	

**These are my beliefs and values about my health care.  
(I know I can change these choices or leave any of them blank.)**

I want you to know these things to help you make decisions about my health care:

My goals for health care:

Some examples:

- *I want to die in my home, if possible.*
- *I have lived a good, long life. I am not afraid to die. If I am near death, I do not want any treatments or procedures that will only prolong my life.*

My goals for health care: \_\_\_\_\_

\_\_\_\_\_

My desire for comfort

Some examples:

- *I do not want to be in pain. I want my pain relieved, even if that means I will be drowsy or sleep more than usual.*
- *I want to be kept alive as long as possible, even if that means I have to endure pain.*
- *I hope that pain and discomfort can be kept to a minimum. I'd rather be awake and aware for the last precious days, unless I'm in too much pain to enjoy them anyway.*

My desires for comfort: \_\_\_\_\_

\_\_\_\_\_

My spiritual or religious beliefs or traditions

Some examples:

- *I want to have others by my side praying for me.*
- *I want my place of worship told that I am sick.*
- *I want my family to know I do not fear death.*

My spiritual or religious beliefs or traditions: \_\_\_\_\_

\_\_\_\_\_

My religion/spirituality is \_\_\_\_\_

My congregation/spiritual community (name, city, state) \_\_\_\_\_

\_\_\_\_\_

I wish to have my (priest/rabbi/shaman/clergy) consulted.

\_\_\_\_\_ Yes \_\_\_\_\_ No

## My beliefs about quality and length of life

Some examples:

- *Do not start or continue life-sustaining procedures if my condition is unlikely to improve and I'm not expected to return to independent functioning.*
- *If I am no longer able to give or receive love, or recognize my family and friends, I consider myself to be in a terminal condition.*

My beliefs about quality and length of life: \_\_\_\_\_

---

---

---

## My wishes about donating parts of my body when I die

*Initial the lines that apply to you:*

\_\_\_\_\_ I **DO** wish to donate organs, tissue or other body parts when I die. I understand that health care professionals will decide what is suitable for donation.

\_\_\_\_\_ Any needed organs, tissue or other body parts

\_\_\_\_\_ Only the following listed organs, tissue or body parts

---

---

Limitations or special wishes I have included \_\_\_\_\_

---

\_\_\_\_\_ I have **made arrangements** for my whole body to be donated to research with (include name of research facility, contact person and phone number): \_\_\_\_\_

---

---

\_\_\_\_\_ I **DO NOT** wish to donate organs, tissue or other body parts when I die

## Additional instructions

Some examples:

- *I know that there are many "gray areas" in end-of-life decision-making. I also know that I cannot anticipate all the possible dilemmas that my decision maker(s) might face. All I ask is that you do your best to figure out what I would want under the circumstances.*
- *Unless indicated here, I nominate my primary health care agent to be my guardian and / or conservator if this becomes necessary.*
- *If it is necessary for me to be placed in a nursing home, I would prefer the following facility: \_\_\_\_\_*

Additional health care instructions: \_\_\_\_\_

---

---

## Part 3: Making the Document Legal

Requires you and others to sign and date this directive.

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

\_\_\_\_\_  
(My signature)

\_\_\_\_\_  
(Date)

If I cannot sign my name, I can ask someone to sign this document for me.

\_\_\_\_\_  
(Signature of person signing)

\_\_\_\_\_  
(Printed name)

### OPTION 1 (verified by Notary Public)

STATE OF MINNESOTA

County of \_\_\_\_\_

\_\_\_\_\_  
Notary stamp

This document was signed or acknowledged  
before me this \_\_\_\_\_ of \_\_\_\_\_,  
(day) (month) (year)

by the above named principal.

\_\_\_\_\_  
(Signature of Notary Public)

### OPTION 2 (verified by two witnesses)

Witness 1:

Witness 2:

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip)

\_\_\_\_\_  
(City) (State) (Zip)

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Phone)

Fill in this card,  
cut it out and  
keep it in your  
wallet upon  
completion of  
your health care  
directive.

#### Notice to Health Care Providers

#### Health Care Directive

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Primary Physician)

\_\_\_\_\_  
(Clinic or Practice Group)

\_\_\_\_\_  
(Place where my health care directive is on file)

*You must sign and  
date your health care  
directive in the presence  
of:*

*Notary Public  
(Option 1)*

*OR*

*Two witnesses  
(Option 2)*

*The notary may be an  
employee of a health care  
provider offering direct care  
to you.*

#### *Witnesses must be:*

- At least 18 years of age*

#### *Witnesses must NOT be:*

- Named as a health care agent or an alternate health care agent in this document*
- A health care provider or employee giving direct care to the author of this document.*



200 STATE AVENUE · FARIBAULT, MN 55021 · 507.334.6451

## REMINDER

1. Make sure you discuss your wishes with your physician.
2. A copy of this signed/dated document is considered a valid, legal document.
3. Keep this health care directive with your personal papers in a safe place (but not in a safety deposit box).
4. This directive should be part of your medical record at your physician's office and at the hospital, home care agency, hospice or nursing facility where you receive care.
5. Give signed copies to your attorney, family, close friends and health care agent(s).
6. Maintain a record of those to whom you have given copies of your health care directive.

### Copies of this health care directive have been given to:

Name

Name

---

---

---

---

---

---

---

---

---

---

**Primary health care agent**

---

(Name)

---

(Home Phone) (Other Phone)

**Alternate health care agent**

---

(Name)

---

(Home Phone) (Other Phone)

