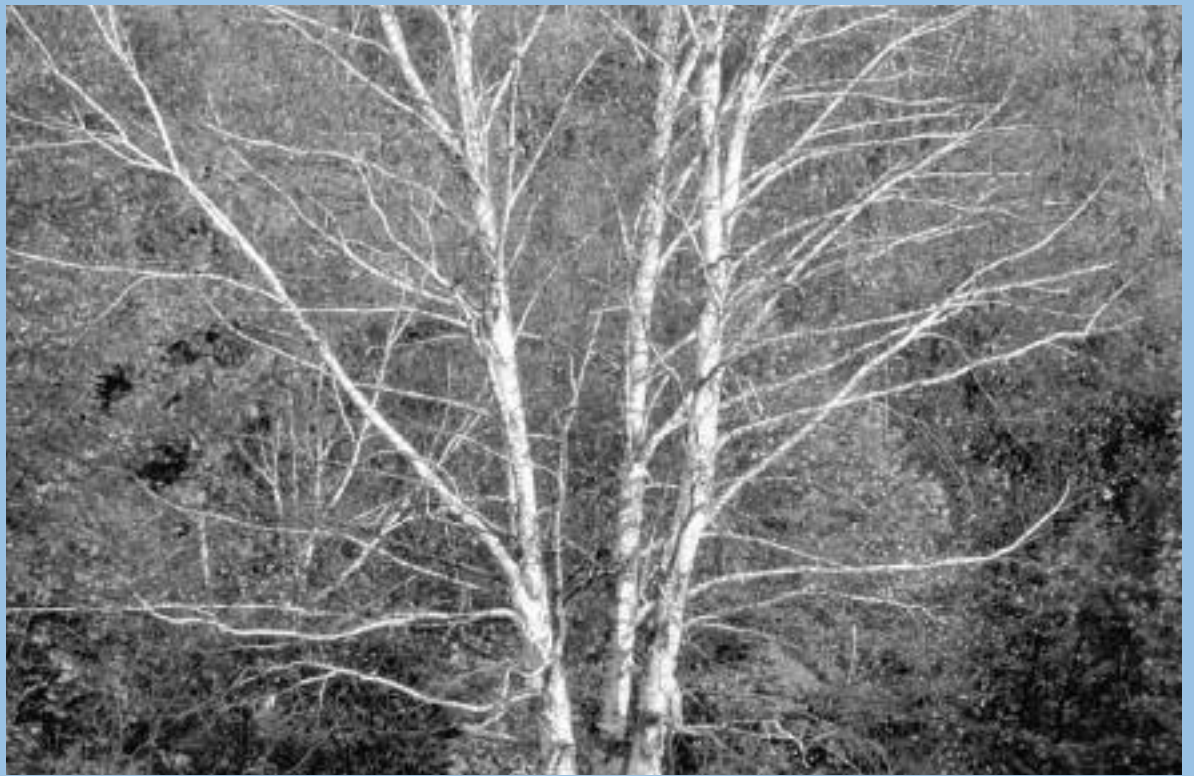


MINNESOTA HEALTH CARE DIRECTIVE



*The right to control your
health care decisions*



200 STATE AVENUE • FARIBAULT, MN 55021 • 507.334.6451

Planning your own health care decisions is a difficult but very important task. The information that follows walks you through the steps of creating your own health care directive. Use this document to specify what types of medical care and treatment you would desire and/or identify someone else to make health care decisions for you when you are unable or unwilling to communicate for yourself.

Taking the time to map out your health care plan is a powerful step. You can rest easy, knowing that your family, friends and health care provider will clearly understand your medical wishes.

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When is a directive used?

There are many situations when having a health care directive is important. Here are a few to consider:

- A single, 25-year-old man is in an auto accident. He arrives at the emergency department of

his local hospital in critical condition and unconscious. According to his medical directive, his cousin is his agent, and he has requested that he not be placed on a ventilator. Without the directive, decision making falls to his parents and their wishes for his care.

- A widowed, 77-year-old man slips into a coma. Without a directive, decision making is left up to his two adult children, who have vastly different opinions about how to treat their father's ongoing medical problems.

- A woman has religious objections to blood transfusions. With her desires expressed in the directive and by identifying an agent, she's assured her wishes will be carried out.

Common Questions and Answers

Q. 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.

Q. 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.

Q. 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.

Q. 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.

Q. How do I make 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 and dated
- State your name
- Be signed by you or someone you authorize to sign for you
- Have your signature verified by a notary public **OR** two witnesses
- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make.

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider.

Q. 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.

Q. What can I put in a health care directive?

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

- The person or persons you trust as your agent(s) to make health care decisions for you. You can name alternate agents in case the first agent is unavailable.
- Your goals, values and preferences about health care.

- The types of medical treatment you would want (or not want).
- How you want your agent or agents to decide.
- Where you want to receive care
- Instructions about artificial nutrition and hydration.
- Mental health treatments.
- Instructions if you are pregnant.
- Donation of organs, tissues and eyes.
- Funeral arrangements
- Who you would like as your guardian or conservator if there is a court action.

You may be as specific or as general as you wish. You can choose which issues or treatments to address in your health care directive.

Q. 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.

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care

Q. How long does a health care directive last?
Can I change it?

Your health care directive lasts until you change or cancel it. Changes are valid as long as they meet the health care directive requirements. You may cancel your directive by doing any of the following:

- Writing a statement to those who have a copy of your directive saying you want to cancel it.
- Destroying it.
- Writing a new health care directive. (Make sure you provide a copy of the new directive to those who need that information.)

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.

Q. 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.

Q. What if I've already prepared a health care document? Is it still good?

Before Aug. 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable health care powers of attorney and mental health declarations.

The law changed so people can use one form for all their health care instructions.

Forms created before Aug. 1, 1998, are still legal if they followed the law in effect when written. They are also legal if they meet the requirements of the new law (see previous page). You may want to review any existing documents to make sure they say what you want and meet all requirements.

Q. 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.

Q. 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.

Minnesota Health Care Directive

Part 1: Allows you to appoint a person (called an agent) to make health care decisions if a doctor decides you are unable to do so or if you choose to have an agent speak for you.

Part 2: Allows you to give written instructions about what you want.

Part 3: Requires you and others to sign and date to make this legal.

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.

My information: (please print)

My full name _____

Address _____

Home 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 _____

Part 1: Naming an Agent

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.

You cannot appoint as **primary** 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.

Your **alternate** agent may be one of your health care providers.

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

Name _____

Relationship to me _____

Address _____

Home phone _____ Cell phone _____

Work phone _____

If my primary agent is a health care provider or employee of a health care 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 or annulment or termination of domestic partnership, I wish my spouse or partner 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 3, I must **INITIAL** the line in front of the power; then my agent **WILL HAVE** that power.

- _____ 1) To decide whether to donate my organs when I die. (See page 6.)
- _____ 2) To decide what will happen with my body when I die (i.e. burial, cremation, anatomical donation to medical science).
- _____ 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.

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.

Part 2: Health Care Instructions

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.

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:

- 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	WHEN IT IS USED AND ITS EFFECT	MY FEELINGS ABOUT THIS PROCEDURE
<p>Cardiopulmonary Resuscitation (CPR)</p> <p>A Do Not Resuscitate (DNR) order is put on your medical record when you don't want this procedure.</p>	<p>Actions to make your heart and lungs start if they stop including chest compressions, electric shocks, medications and a tube in your throat.</p>	
<p>Nutrition support and hydration</p>	<p>When you can't eat or drink by mouth, feeding solutions can provide enough nutrition to support life.</p> <p>Feeding solutions can be put through a tube in your stomach, nose, intestine or veins.</p>	
<p>Ventilator or Respirator (a breathing machine)</p> <p>A Do Not Intubate (DNI) order is put on your medical record when you don't want this procedure</p>	<p>When you cannot breathe on your own, a tube down your throat and a machine do it for you.</p> <p>You can't talk or eat by mouth on this machine</p>	
<p>Dialysis</p>	<p>A mechanical means of cleaning the blood when kidneys aren't working.</p>	
<p>Blood transfusions</p>	<p>Receiving components of human blood to provide multi-system stability.</p>	

**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 want to have people with me when possible.*

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 it is necessary for me to be placed in a nursing home, I would prefer the following facility: _____*

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.*
 - *In case of court action, I appoint _____ as my guardian or conservator.*

Additional health care instructions : _____

Part 3: Making the Document Legal

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)

Notary seal here

STATE OF MINNESOTA

County of _____

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:

(printed name)

(signature)

Address _____

City _____

State _____ Zip _____

Telephone number _____

Witness 2:

(printed name)

(signature)

Address _____

City _____

State _____ Zip _____

Telephone number _____

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

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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.

Primary health-care agent

Name _____

Home phone _____

Other phone _____

Alternate health-care agent

Name _____

Home phone _____

Other phone _____



200 STATE AVENUE • FARIBAULT, MN 55021 • 507.334.6451

COPIES OF THIS HEALTH CARE DIRECTIVE HAVE BEEN GIVEN TO:

NAMES

NAMES

REMINDER

- A copy of this signed/dated document is considered a valid, legal document.
- Make sure you discuss your wishes with your physician.
- 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.
- Give signed copies to your attorney, family, close friends and health care agent(s).
- Keep this health care directive with your personal papers in a safe place (but not in a safety deposit box).
- Maintain a record of those to whom you have given copies of your health care directive.

HEALTH CARE DIRECTIVE

My name _____

My primary physician _____

Clinic or practice group _____

My primary hospital _____

City, State _____