Healthcare Directive

Introduction

This document gives my treatment choices and preferences, and/or appoints a Healthcare Decision Maker to speak for me if I cannot communicate or make my own healthcare decisions. My Healthcare Decision Maker, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

Any advance directive document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

My telephone numbers: (home) _____ (cell) _____

Part 1: My Healthcare Decision Maker

If my healthcare team determines that I cannot communicate my wishes and healthcare decisions due to illness or injury or that I cannot make my own healthcare decisions, I choose the following person(s) to communicate my wishes and make my healthcare decisions. If my Healthcare Decision Maker acts, they must to the best of their ability and good faith effort:

- Follow my healthcare instructions in this document.
- Follow any other healthcare instructions I have given to him or her.
- Make decisions in my best interest if my decisions and wishes are not known.

My Primary (main) Healthcare Decision Maker is:

Name: _____ Relationship: _____

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

Full address: _____

If I cancel my primary agent's authority, or if my primary agent is not willing, able, or reasonably available to make healthcare decisions for me, I choose an alternate Healthcare Decision Maker.

My Alternate Healthcare Decision Maker is:

Name: _____ Relationship: _____

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

Full address: _____

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This is the directive of (Name):_____ **Date:**_____

I understand my Healthcare Decision Maker (primary or alternate) cannot be a healthcare provider or employee of a healthcare provider giving direct care to me unless I:

- Am related to that person by blood or marriage, registered domestic partnership, or adoption, and,
- Provide a clear reason why I want that person to serve as my agent:

Powers of my Healthcare Decision Maker: My Healthcare Decision Maker automatically has all the following powers when I am unable to communicate for myself:

A. Agree to, refuse, or cancel decisions about my healthcare. This includes tests, medications, surgery, taking out or not putting in tube feedings, and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it.

B. Interpret any instruction in this document based on their understanding of my wishes, values and beliefs.

C. Review and release my medical records and personal files as needed for my healthcare, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Minnesota Health Records Act.

D. Arrange for my healthcare and treatment in Minnesota or other state or location he or she thinks is appropriate.

E. Decide which healthcare providers and organizations provide my healthcare.

F. Make decisions about organ and tissue donation and autopsy according to my instructions in Part 2 of this document.

Please inital all the boxes that you would like your Healthcare Decision Maker to be able to do. I also authorize my Healthcare Decision Maker to:

☐ Make decisions about the care of my body after death.

☐ Continue as my Healthcare Decision Maker even if our marriage or domestic partnership is legally ending or has been ended.

☐ Make healthcare decisions for me even if I am able to decide or speak for myself, if I so choose.

☐ In the event I am pregnant, decide whether to try to continue my pregnancy to delivery based upon my Healthcare Decision Maker's understanding of my values, preferences and/or

instructions.

Part 2: My Healthcare Instructions

My choices and preferences for healthcare are listed below. I ask my Healthcare Decision Maker to speak with my healthcare team and to honor my choices as best as possible. If I cannot communicate or make my own choices, I have initialed a box below for the option I prefer for each situation.

1. Cardiopulmonary Resuscitation (CPR)

CPR is a treatment used to attempt to restart the heart and lungs when they have stopped working. CPR may include forceful pushing on the chest to make the blood circulate, medications, electrical shocks, a breathing tube, and hospitalization. I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have long-term diseases or poor overall health, or both. I understand that recovery from CPR can be painful and difficult.

Therefore:

☐ I want CPR attempted if my heart or lungs stop working.

or

☐ I want CPR attempted if my heart or lungs stop working based on a decision made by my Healthcare Decision Maker and healthcare team.

or

☐ I do not want CPR attempted if my heart or lungs stop working. I want to allow a natural death.

2. Treatments to Prolong My Life:

If I can no longer make decisions for myself, and my healthcare team and Healthcare Decision Maker believe I will not get better I want:

☐ To stop and not start any treatments that extend my life.

or

☐ I want treatments to continue until my healthcare team and Healthcare Decision Maker agree these treatments are harmful or no longer helpful.

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

3. Organ donation (the act of cutting and dissecting a person for the purpose of removing organs to be shared with another person whose organs no longer work)

☐ I want to donate my eyes, tissues and/or organs, if able.

or

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

or

☐ My Healthcare Decision Maker can decide.

4. Autopsy (the act of cutting and dissecting a person for medical or legal purposes)

☐ My Healthcare Decision Maker may request an autopsy if the autopsy can help others understand the cause of my death or help with future healthcare decisions of others.

or

☐ I do not want an autopsy unless required by law.

5. Please write special directions and wishes for your Healthcare Decision Maker and healthcare team here:

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Part 3: My Hopes and Wishes

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

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

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

The humor I would like to impart:

My thoughts about specific medical treatments:

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

Other things that I want to address:

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.):

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Center of American Indian and Minority Health | caimh.umn.edu | 218-726-7235 | caimh@d.umn.edu

This is the directive of (Name):______________________________________ Date:____________

My thoughts and instructions for Healthcare Decision Maker:

The spiritual leader I would like notified:

Ceremonies I would like conducted:

The spiritual items I would like with me (i.e. feathers, etc.):

How I want my earthly body to be cared for and handled after my last breath:

Any other items I would like to address:

Other wishes and instructions:

My initials here indicate additional documents are attached. ☐

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This is the directive of (Name):_____ **Date:**_____

Part 4: Legal Authority

NOTE: Under Minnesota law, 2 witnesses or a notary public must verify your signature and the date. Your witnesses or notary public cannot be named as your primary or alternate Health Care Agent.

I have made this document willingly. I am thinking clearly. This document states 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:

_____ _____

Printed Name **Signature** *(of person asked to sign)*

Statement of Witnesses:
This document was signed or verified in my presence. I certify that I am at least 18 years of age, and I am not appointed as a primary or alternate 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: _____. One witness cannot be a provider or an employee of the provider giving direct care on the date this document is signed.

Witness 1:

Signature _____

Date: _____

Print name

_____

Address (optional)

_____

_____

Witness 2:

Signature _____

Date: _____

Print name

_____

Address (optional)

_____

_____

Or

Notary Public:

In the state of Minnesota, County of _____.

In my presence on _____ (date), _____ (name) acknowledged his or her signature on this document or 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:*

My commission expires (date):

Part 5: Next Steps

Now that I have completed my Healthcare Directive, I will also:

- Tell my primary and alternate Healthcare Decision Maker so that they can help me honor my wishes in the future.
- Give my primary and alternate Healthcare Decision Makers a copy of this completed Healthcare Directive.
- Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Healthcare Decision Maker is, and what my wishes are.
- Give a copy of this completed Healthcare Directive to my doctor and other healthcare providers, and make sure they understood and will follow my wishes.
- Keep a copy of my Healthcare Directive where it can be easily found.
- Take a copy of my Healthcare Directive any time I am admitted to a healthcare facility, and ask that it be placed in my medical record.
- **Review my healthcare wishes every time I have a change of "HEART" (Health, Event, Age, Relationships, Thinking):**

Decade: when I start each new decade of my life. Death: whenever I experience the death of a loved one. Divorce: when I experience a divorce or other major family change. Diagnosis: when I am diagnosed with a serious health condition. Decline: when I experience a significant decline or deterioration of an existing health condition, especially when I am unable to live on my own.

Copies of this document have been given to:

Primary (main) Healthcare Decision Maker (listed on page 1 of this document)

Name: ______________________________ Telephone: ____________________

Alternate Healthcare Decision Maker (listed on page 1 of this document)

Name: ______________________________ Telephone: ____________________

Healthcare Provider/Clinic

Name: ______________________________ Telephone: ____________________

Name: ______________________________ Telephone: ____________________

If my wishes change, I will fill out a new Healthcare Directive. I will give copies of the new document to everyone who has copies of my previous Healthcare Directive. I will tell them to destroy the previous version.

This is the directive of (Name):______________________________ Date:____________