Allina Health

My Health Care Directive

Legal name: _____

Date of birth: _____

Address: _____

Telephone: (Home) _____ (Cell) _____

My health care directive was created to guide my care circle (family, friends or others close to me) and health care agent(s) to make health care decisions on my behalf if illness or injury prevents me from deciding or communicating them myself at the time of care.

I understand that my health care agent and my health care provider(s) may not be able to honor my wishes, goals and values in every circumstance.

Any health care directive document created before this is no longer valid.

My Health Care Agent

I have chosen a health care agent to speak for me if:

- I am unable to communicate my wishes, goals and values, and health care decisions due to illness or injury

  or

- my health care providers have determined I am not able to make my own health care decisions.

When choosing a health care agent, I have considered that person's ability to willingly make decisions based on my choices. I trust this person to follow my wishes, goals and values under stress.

I understand that my health care agent must be 18 years of age or older.

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My primary (main) health care agent is:

Name: _____

Relationship: _____

Address: _____

Telephone (Home) _____ (Cell) _____

Alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent is not available or willing to serve as my health care agent:

Name: _____

Relationship: _____

Address: _____

Telephone (Home) _____ (Cell) _____

Powers of my health care agent

My health care agent automatically has all of the following powers when I am unable to make my own health care decisions:

- make decisions about my health care, including decisions to start, stop or change treatments for me. This includes taking out or not putting in tube feedings, tests, medicine, surgery, and other decisions about treatments including mental health treatments or medicines. If treatment has already begun, my health care agent can continue or stop it based on verbal and/or written instructions.
- interpret any instructions in this document according to your health care agent's understanding of my wishes, goals and values
- review and release my medical records, health information and other personal records as needed for my health care as a personal representative under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state law

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- arrange for my health care and treatment in any state or location your health care agent thinks is appropriate
- decide which health care providers and organizations provide my care and treatment.

Note: Your health care agent cannot make decisions about your finances. Consider talking with a lawyer about filling out a Financial Power of Attorney document if you would like to make sure you give someone power to make financial decisions or complete financial transactions on your behalf.

Additional powers of my health care agent

If I want my health care agent to have any of the following powers, I have initialed the box(es) below.

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

☐ Continue as my health care agent even if our marriage or domestic partnership is legally ending or has ended.

☐ If I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon your health care agent's understanding of my wishes, goals, values and instructions.

Cardiopulmonary Resuscitation (CPR)

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 blood circulate), medicines, electrical shocks, a breathing tube and a hospital stay.

I understand that:

- CPR can save a life but it does not always work
- CPR does not work as well for people who have chronic (long-term) diseases
- CPR may result in injury, and recovery from CPR can be painful and difficult.

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Note: Make this choice based on your health today. You can always update your health care directive as you age or your health changes.

I have initialed the option I prefer for this situation. My choice about CPR is:

☐ **I want CPR** attempted if my heart or breathing stops in all circumstances.

☐ **I want CPR** attempted if my heart or breathing stops **except when** my health care provider has determined that I have little or no reasonable chance of survival even with CPR.

☐ **I do not want CPR** attempted if my heart or breathing stops. I prefer a natural death. If I choose this option, I should talk with my health care provider.

Treatments to Extend My Life

If my health care providers determine I am in a vegetative state, or that I have a permanent brain injury that means it is very likely I will not regain consciousness or recover my ability to know who I am, I choose the following.

Note: With any choice, you will continue to be offered pain medicines and care to help you be comfortable (comfort measures) as well as food and liquids by mouth if you are able to swallow.

I have initialed the option I prefer for this situation. My choice is:

☐ **I would want to stop or withhold all treatments** that are extending my life at this time. This includes, but is not limited to, tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), CPR and antibiotics (medicines).

☐ **I would want all the treatments** recommended by my health care team until they agree that such treatments are harmful and no longer helpful. This includes, but is not limited to, tube feedings, IV fluids, respirator/ventilator, CPR and antibiotics.

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☐ **I would want to receive limited treatment.** I would want to receive certain types of care in certain circumstances, as I've written below. For example, you may write that you want to live on life support until all of your care circle has arrived.

_____

_____

_____

_____

Organ Donation

Organ donation is donating organs, eyes, tissues or any other body part to other people in need.

I have initialed the option I prefer for this situation.

☐ **I do not** want to donate my organs, eyes, tissues or any other body parts. I do not allow this donation after I die.

☐ **I do** want to donate any or all of my organs, eyes, tissues or other body parts. I allow this donation after I die. My health care agent is authorized to start or continue supportive treatments or any interventions needed to maintain my organs, eyes, tissues or any other body part until donation has been completed.

☐ **I do** want to donate, but I want to **limit** my tissue and organ donations. I authorize the limited donation, as I've written below, after I die. My health care agent is authorized to start or continue supportive treatments or any interventions needed to maintain my organs, eyes, tissues or any other body part until donation has been completed.

_____

_____

☐ **I have not decided** whether to donate any or all of my organs, eyes, tissues or other body parts. I authorize my health care agent to make this decision after I die.

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Values and Beliefs

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

_____

_____

_____

_____

Pain Management Values

My thoughts on how pain management affects my quality of life:

_____

_____

_____

_____

Religious, Spiritual or Faith Affiliation

I am of the _____ faith, and am a member of the _____ faith community in (city) _____. Please try to notify them of my death and arrange for them to provide my after-death arrangements or memorial service.

I prefer to be buried/cremated. (circle one)

Instructions for care of my body after death:

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Making My Health Directive Valid

Under Minnesota law, you must sign and date this document in Minnesota in front of a notary public **or** two witnesses.

- Your notary or witnesses cannot be someone who is named as a health care agent in this document.
- Your notary cannot be a health care provider (but *can* be an employee of a health care provider) caring for you at the time you sign this document.
- If you sign before two witnesses, only one of the two witnesses can be a health care provider (or an employee of a health care provider) caring for you at the time you sign this document.

Important: Wait to sign your name until you are in front of either a notary public or two witnesses. The signature dates must match.

I have made this document willingly. I am thinking clearly. This document expresses my choices about my health care decisions:

Signature: _____ Date: _____

If I cannot sign my name, I ask the following person to sign for me:

Signature: _____

Print name: _____ Date: _____

The reason I cannot sign my name is:

_____

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Option 1: Notary public

In my presence on _____ (date), _____(name of person completing this health care directive) acknowledged their signature on this document or acknowledged that they authorized the person signing this document to sign on their behalf. **I am not named as a health care agent or alternate health care agent in this document.**

Important

If you use a notary public, you do not need 2 witnesses.

County of: _____

(where document is signed)

Witness my hand and seal:

Notary signature: _____

My commission expires (date): _____

Notary stamp:

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Option 2: Two witnesses

I declare that:

- ■ this document was signed in my presence by the person completing this document or by an individual that the person completing this document authorized to sign on their behalf
- ■ I am at least 18 years of age
- ■ I am not named as a health care agent in this document.

Important

If you use 2 witnesses, you do not need a notary public.

Note: Only one of the two witnesses can be a health care provider (or an employee of a health care provider) caring for you at the time you sign this document.

Signature of Witness 1:

Signature: _____ Date: _____

Print name: _____

Address: _____

Are you a health care provider (or employee of a health care provider) giving direct care to the person creating this health care directive?

❑ yes ❑ no

Signature of Witness 2:

Signature: _____ Date: _____

Print name: _____

Address: _____

Are you a health care provider (or employee of a health care provider) giving direct care to the person creating this health care directive?

❑ yes ❑ no

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