Minnesota
Health Care Directive

Purpose of form

Part I. Allows you to appoint another person (called an agent) to make health care decisions if a doctor decides you are unable to do so.
Part II. Allows you to give written instructions about what you want.
Part III. Requires you and others to sign and date to make this legal.

My personal information

My name: _____
Address: _____
_____
Home phone: ( ) _____
Work phone: ( ) _____
Date of birth: _____
Social security #: _____

- I revoke all living wills, Durable Powers of Attorney for Health Care, or other written advance health care directives I have signed in the past.

PART 1: Naming An Agent

Agent duties

My health care agent can:

- Make health care decisions for me if I am unable to make and communicate decisions for myself.
- Make decisions based on any instructions in Part II of this document or in other documents.
- Make decisions based on what he or she knows about my wishes.
- Act in my best interests if instructions are not available.

Agent roles

- When naming my health care agent, I must choose one of the following. *Initial the line in front of the statement you WANT.*

Act alone

_____ I appoint one person to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.

Act together

_____ I appoint two or more persons to act together as my health care agent. My primary agent and alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.

My primary health care agent

I appoint:
Agent's name: _____
Address: _____
_____
Home phone: ( ) _____
Work phone: ( ) _____

My first alternate health care agent

Agent's name: _____
Address: _____
_____
Home phone: ( ) _____
Work phone: ( ) _____

My second alternate health care agent

Agent's name: _____
Address: (3 lines) _____
_____
Home phone: ( ) _____
Work phone: ( ) _____

(If needed) Reasons for naming health care provider

I have named as my agent a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed.

____That person is related to me by blood, marriage, registered domestic partnership, or adoption.

____My reasons for wanting to appoint that person as my agent are:
_____
_____

Powers of my agent

If I am unable to decide or speak for myself, my agent has the power to:

- Consent to, refuse, or withdraw any health care, treatment, service, or procedure
- Stop or not start health care which is keeping or might keep me alive
- Choose my health care providers
- Choose where I live when I need health care and what personal security measures are needed to keep me safe.
- Obtain copies of my medical records and allow others to see them.

Additional powers of my agent

If I WANT my agent to have any of the following powers, I must initial the line in front of the statement.

I also authorize my agent to:

_____ Make health care decisions for me even if I am able to decide or speak for myself.

_____ Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die.

_____ Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics.

_____ In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions.

_____ Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in process or has been completed.

Limiting the powers of my agent

I wish to limit the powers of my health care agent in the following way(s): _____

_____

PART II: Health Care Instructions

- I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments or situations) _____

_____

_____

_____

_____

_____

_____

_____

- I am attaching additional instructions concerning my health care values and preferences. *Initial one line:* _____ Yes _____ No

- I authorize donation of organs, tissue, or other body parts after my death. *Initial one line:* _____ Yes _____ No

PART III: Making This Document Legal

My signature/ mark and date

I agree with everything in this document and have made this document willingly:

My signature: _____

Date: _____
(day / month / year)

Notary Public OR Witnesses

Notary Public

NOTE: Must not be named as agent or alternate agent.

STATE OF MINNESOTA

County of _____

This document was signed or acknowledged before me this _____
(day)

of _____ , _____ by the above named principal.
(month) (year)

_____
Signature of Notary Public

Two Witnesses

NOTE: Only one witness can be a direct care provider or employee of a provider on the day this is signed.

This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document.

Witness Signature: _____
Address: _____
_____
Date: _____
(month / day / year)

Witness Signature: _____
Address: _____
_____
Date: _____
(month / day / year)

Health Care Instructions Worksheet
Part II Of Minnesota Health Care Directive

MY HEALTH CARE GOALS

Having a sense of what is important to you can help your decisionmakers make health care decisions under different and complex circumstances. Read each statement below and on a scale of "0" to "4," rate how important each of the health care goals are to you. In this case, "4" means "Extremely Important and "0" means "Not Important At All." Remember reasonable medical care should always include maintaining a person's comfort, hygiene, and human dignity.

HEALTH CARE GOALS	Not Important 0	1	Somewhat Important 2	3	Extremely Important 4
How Important Is Pain Control?					
• Being as comfortable and free from pain as possible					
• Having pain controlled, even if my ability to think clearly is reduced					
• Having pain controlled, even if it shortens my life					
How Important Is the Use of Life Prolonging Treatment When:					
• I have a reasonable chance of recovering both physically and mentally (50/50+)					
• I have some physical limitations but can socially relate to those I care about					
• I can live a longer life no matter what my physical or mental health					
• I have little or no chance of doing everyday activities I enjoy					
• I am not able to socially relate to those I care about					
• I have a terminal illness and treatment will only prolong when I die					
• I have severe and permanent brain injury and there is little chance of regaining consciousness					
• I have severe dementia or confusion and my condition will only get worse					
Importance of Finances and Health Care					
• Having my wishes followed regardless of whether or not my finances are exhausted					
• Not being a financial burden to those around me					
• Not having my health care costs affect the financial situations of those I care about					

I also want my decisionmakers to know the following things are important to me when receiving health care: _____

_____

My Medical Treatment Preferences

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 future health conditions.

Medical Procedure	When It Is Used and Its Effects	My Feelings About This Procedure
Ventilator/Respirator A breathing machine A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure	When you cannot breathe on your own You cannot talk or eat by mouth on this machine	
Nutrition support and hydration	When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely. Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins.	
Cardiopulmonary Resuscitation (CPR) A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.	Actions to make your heart and lungs start if they stop including pounding on your chest, electric shocks, medications, and a tube in your throat.	
Dialysis	A mechanical means of cleaning the blood when kidneys are not working.	

My feelings or concerns about other medical treatments include: _____

_____

_____

If I am pregnant, my feelings about medical treatment would include: _____

_____

_____

My Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying or when they have died.

My decision makers should know the following about how my religious or spiritual beliefs should affect my health care: _____

_____

_____

My religion/spirituality/ is: _____

My congregation/spiritual community (name, city, state): _____

_____

I wish to have my (priest/pastor/rabbi/shaman/spiritual leader) consulted. _____Yes _____No

If yes, the person to be contacted is (name/contact information) _____

Feelings About Quality and Length of Life

I have the following beliefs about whether life should be preserved as long as possible: _____

_____

_____

The following kinds of mental or physical conditions would make me think that medical treatment should no longer be used to keep me alive _____

_____

_____

_____

My Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

_____ At home _____

_____ At a hospital. Which one? _____

_____ At a nursing home. Which one? _____

_____ Through hospice services/care. Which one? _____

_____ From other health care providers. Which ones? _____

Other wishes I have about my care if I am dying _____

_____

My Wishes About Donating Organs, Tissues, or Other Body Parts

Initial the lines that apply to you:

_____ I DO wish to donate organs, tissue, or other body parts when I die

_____ Any needed organs, tissue, or other body parts

_____ Only the following listed organs, tissue, or body parts_____

_____

Limitations or special wishes I have include: _____

_____

_____ I DO NOT wish to donate organs, tissue, or other body parts when I die

Additional Health Care Instructions

My decision makers should also know these things about me to help them make decisions about my health care:

_____

_____

_____

I agree that these are my health care instructions and have completed this willingly.

My signature: _____

Date completed: _____
(month / day / year)

- This worksheet is an attachment to my Health Care Directive:

Initial one box: _____ Yes _____ No

Current as of 2008: mss:Stum104-d

What you should do with this Advance Directive

- Register your Estate Planning Documents for no fee at www.TheUSWillRegistry.Org
- It is suggested that you have your attorney review this form to be assured that it meets all your current state requirements.