Minnesota Health Care Directive

NORTH MEMORIAL HEALTH

- This document replaces any health care directive made before this one.
- This document is for health care decisions; it does not apply to financial decisions.
- This document does not apply to electroconvulsive therapy or neuroleptic medications for mental illness.
- I will give copies to my health care agents and health care teams when completed.
- I will make a new health care directive if my agents, goals, preferences, or instructions change.

My Full Name: _____ My Date of Birth: _____

My Address: _____

My Phone Number(s): _____

My Health Care Agent(s)

My health care agent is my voice if I can't make health care decisions myself. My agent(s) are at least 18 years old.

Health Care Agent

Name:_____ Relationship To Me: _____

Address:_____

Cell #:_____ Home #:_____

First Alternate Health Care Agent — If my health care agent is not willing, able, or reasonably available.

Name:_____ Relationship To Me: _____

Address:_____

Cell #:_____ Home #:_____

Second Alternate Health Care Agent — If my health care agent is not willing, able, or reasonably available.

Name:_____ Relationship To Me: _____

Address:_____

Cell #:_____ Home #:_____

☐ My initials here indicate I attached additional pages that identify additional health care agents. I included instructions on order of health care agents decision making.

Health Care Agents: Powers and Special Situations

If I'm not able to make my own health care decisions, my health care agent can: access my medical records, decide when to start and stop treatments, and choose my health care team and place of care consistent with my known wishes.

I also want my health care agent to:

☐ Make decisions about how a pregnancy, if any, should affect health care decisions on my behalf.

☐ Make decisions about the care of my body after I die (including: autopsy, burial, cremation).

☐ Continue as my Health Care Agent even if our marriage has legally ended.

(Per MN law, spouses named as health care agents are NO LONGER VALID in the event of divorce/annulment unless this box is checked)

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FULL NAME:	DATE OF BIRTH (mm/dd/yyyy):	Date:

My Future Care Preferences

If I were so sick that I may die soon *(due to: a prolonged illness, a sudden serious event like heart attack or stroke, a permanent brain injury due to an accident, etc.)* then I would prefer:

☐ **Try and/or continue all treatments to extend my life,** even if there is little hope of getting better or living a life I value. May include but not limited to: tube feedings, IV fluids, respirator/ventilator (breathing machine), CPR and antibiotics (medicine).

☐ **I would want a trial of life support treatments.** But, I **DO NOT** want to stay on life support treatments if the treatments do not work and there is little hope of getting better or living a life I value.

☐ **I would want to stop and/or not start any treatment that may artificially extend my life.** Focus on making me comfortable and allow natural death.

NOTE: You can include additional information/specific requests on the "My Goals & Values" sheet.

Organ Donation

☐ **I want to donate my eyes, tissues and/or organs, if I can.** My health care agent may start and continue any treatments needed until the donation is complete.

☐ **I don't want to donate my eyes, tissues and/or organs.**

Making This Document Legal

1. **Sign and date:** My Signature: _____ Date Signed: _____

2. **Have your signature notarized <u>OR</u> verified by 2 witnesses**

MINNESOTA NOTARY PUBLIC: County: _____ In my presence on: _____
Date notarized

Name: _____ acknowledged their signature on this document.
Name of person signing above

Signature of Notary: _____ NOTARY SEAL:
I am not named as a healthcare agent in this document.

OR

STATEMENT OF WITNESSES: I am at least 18 years old. I am **<u>not</u>** named as a health care agent in this document. Only one witness can be an employee of the health care system providing direct care to me on the date that I sign this document.

Witness # 1 Signature: _____ Witness # 2 Signature: _____

Date Signed: _____ Date Signed: _____

Print Name: _____ Print Name: _____

My Goals and Values

Optional Addendum to Minnesota Health Care Directive

NORTH MEMORIAL HEALTH

FULL NAME:	DATE OF BIRTH (mm/dd/yyyy):	Date:

Some people are willing to live through a lot for a chance of living longer. Some people fear that medical treatments may cause suffering without much benefit. What would you want? These answers will be used to guide your health care agent(s) to make health care decisions based on your wishes if you cannot make them yourself.

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

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

Other choices/instructions:

My idea of a good death and where I would want to be (at home, in the hospital, or ?):

When I am dying, I would find comfort and support from:

After I die, these are my wishes about what to do with my body (autopsy, burial/cremation) and how I wish to be remembered (obituary, funeral, celebration, memorial service, etc):