MINNESOTA HEALTH CARE DIRECTIVE

I, _____, understand this document allows me to do ONE OR BOTH of the following:

PART I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.
AND/OR
PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF
(I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent)
NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

When I am unable to decide or speak for myself, I trust and appoint _____ _____ to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me: _____

Telephone number of my health care agent: _____

Address of my health care agent: _____

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint _____to be my health care agent instead.

Relationship of my alternate health care agent to me: _____

Telephone number of my alternate health care agent: _____

Address of my alternate health care agent: _____

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF (I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.
Whenever I am unable 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 that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.
(B) Choose my health care providers.
(C) Choose where I live and receive care and support when those choices relate to my health care needs.
(D) Review my medical records and have the same rights that I would have to give my medical records to other people.
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:

_____

_____

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

_____ (1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

_____ (2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

_____

PART II: HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

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). 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 about me to help you make decisions about my health care:

1. My goals for my health care: _____

_____

2. My fears about my health care: _____

_____

3. My spiritual or religious beliefs and traditions: _____

_____

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

_____

5. My thoughts about how my medical condition might affect my family: _____

_____

6. (For a woman of childbearing age) My thoughts about how my health care should be handled in the event I am pregnamt: _____

_____

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE
(I know I can change these choices or leave any of them blank)
Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.
I have these views about my health care in these situations:
(Note: You can discuss general feelings, specific treatments, or leave any of them blank)

1. If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want: _____

_____

2. If I were dying and unable to decide or speak for myself, I would want: _____

_____

3. If I were permanently unconscious and unable to decide or speak for myself, I would want: ___

_____

4. If I were completely dependent on others for my care and unable to decide or speak for myself, I would want: _____

_____

5. In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life _____

_____

There are other things that I want or do not want for my health care, if possible:

1. Who I would like to be my doctor: _____
2. Where I would like to live to receive health care: _____

   _____
3. Where I would like to die and other wishes I have about dying: _____

   _____
4. My wishes about donating parts of my body when I die: _____
5. My wishes about what happens to my body when I die (cremation, burial): _____

   _____
6. Any other things: _____

_____

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed. I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

_____
My Signature

Date signed: _____

Date of birth: _____

Address: _____

_____

If I cannot sign my name, I can ask someone to sign this document for me.

_____
Signature of the person who I asked to sign this document for me.

_____
Printed name of the person who I asked to sign this document for me.

Option 1: Notary Public

In my presence on _____ (date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

Subscribed and sworn to before me this _____day of _____, 20___

_____

(Signature of Notary) (Notary Stamp)

OR

Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One:

(i) In my presence on _____ (date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
(ii) I am at least 18 years of age.
(iii) I am not named as a health care agent or an alternate health care agent in this document.
(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

_____

(Signature of Witness One)

Address: _____

_____

Witness Two:
(i) In my presence on _____ (date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
(ii) I am at least 18 years of age.
(iii) I am not named as a health care agent or an alternate health care agent in this document.
(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

_____
(Signature of Witness Two)

Address: _____

_____

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.