

## MINNESOTA HEALTH CARE DIRECTIVE

<b>Purpose</b>	<p><b>Part I:</b> Allows you to appoint another person as agent to make health care decisions if your physician decides you are unable to do so.</p> <p><b>Part II:</b> Allows you to give written instructions about your wishes.</p> <p><b>Part III:</b> Requires you and others to sign to make this a legal document.</p>
----------------	---

<b>Personal Information</b>	Your Name:	
	Address:	
	Home Phone: (    )	Work Phone: (    )
	Birthdate:	
	Social Security Number:	

**This form revokes all Living Wills, Durable Power of Attorney for Healthcare, or other written Advanced Health Care Directives previously signed by you.**

### PART I: APPOINTING A PRIMARY AND ALTERNATIVE AGENT

<b>General Statement of Responsibility</b>	<p>My health care agent may:</p> <ul style="list-style-type: none"> <li>• Make health care decisions for me if I am unable to make and communicate decisions for myself,</li> <li>• Make decisions based on any instructions in Part II of this document,</li> <li>• Make decisions based on what he or she knows about my wishes,</li> <li>• Act in my best interests if instructions are not available.</li> </ul> <p>If I am unable to decide or speak for myself, my agent has the power to:</p> <ul style="list-style-type: none"> <li>• Consent to, refuse, or withdraw any health care keeping me alive and decide about intrusive mental health treatments,</li> <li>• Choose my health care providers,</li> <li>• Choose where I live, when I need health care and what personal security measures are needed to keep me safe,</li> <li>• Obtain copies of my medical records and allow others to see them.</li> </ul>
--	---

<b>Primary Healthcare Agent</b>	<b>I appoint:</b>	
	Agent's Name:	
	Address:	
	Home Phone: (    )	Work Phone: (    )
	Relationship:	
<b>Alternate Healthcare Agent</b>	<b>I appoint:</b>	
	Agent's Name:	
	Address:	
	Home Phone: (    )	Work Phone: (    )
	Relationship:	

<b>Healthcare Provider as Agent</b>	<input type="checkbox"/> No, I choose not to appoint a Health Care Provider as my agent. <input type="checkbox"/> Yes, I choose to appoint _____ as my agent.  I have named a healthcare provider as my agent who may be providing care to me when decisions are needed. That person is not related to me by blood, marriage, registered domestic partnership, or adoption. My reasons for appointing this person my agent are (list below):  _____ _____ _____ _____ _____
-------------------------------------	--

**PART II: INSTRUCTIONS ABOUT MY HEALTHCARE (Initial each response. Do not leave any blank. )**

<b>IF THERE IS A REASONABLE CHANCE OF RECOVERY</b>	<b>YES</b>	<b>NO</b>
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		
Blood Transfusions		
<b>Pain relief even if it affects my alertness or unintentionally shortens my life</b>		

<b>IF THERE IS <u>NO</u> REASONABLE CHANCE OF RECOVERY</b>	<b>YES</b>	<b>NO</b>
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		
Blood Transfusions		
<b>Pain relief even if it affects my alertness or unintentionally shortens my life</b>		

Other
-------

<b>Preferences for Care When Dying</b>	<p>If possible and reasonable when dying, I would prefer to receive care:</p> <p><input type="checkbox"/> At home</p> <p><input type="checkbox"/> At a hospital. Which one: _____</p> <p><input type="checkbox"/> At a nursing home. Which one: _____</p> <p><input type="checkbox"/> Through hospice services/care: Which one: _____</p> <p><input type="checkbox"/> From other health care providers. Which one: _____</p> <p><input type="checkbox"/> I would like to have as my physician. Dr. _____</p>
	<p><b>YES</b>   <b>NO</b></p> <p><input type="checkbox"/>   <input type="checkbox"/> Additional instructions regarding my healthcare values/preferences are attached.</p> <p><input type="checkbox"/>   <input type="checkbox"/> I authorize donation of organs, eyes, tissue, or other body parts after my death.</p>
<b>Additional wishes after death</b>	<p>The following are my wishes regarding my body after I die: (ex. Burial, cremation, autopsy)</p> <p>_____</p> <p>_____</p> <p>_____</p>

**PART III: MAKING THIS DOCUMENT LEGAL**

<b>Signature and Date</b>	<p>I understand and agree with everything in this document and have made this document willingly:</p> <p>Signature: _____</p> <p>Date: _____</p>
<b>Notary Public</b> (Must not be named agent or alternate agent)	<p><b>STATE OF MINNESOTA</b></p> <p>This document was signed or acknowledged before me by the above named principal.</p> <p>County of _____</p> <p>Notary Signature _____</p> <p>Date (month/day/year) _____</p>

<b>Two Witnesses</b> (Must not be named agent or alternate agent)	This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document.
	Witness Signature #1: _____
	Address: _____
	Date (month/day/year) _____
	_____
	Witness Signature #2: _____
	Address: _____
Date (month/day/year): _____	

<b>Modification or Cancellation of the Health Care Directive</b>	<p>Your health care directive is effective unless you change or cancel it by any of the following:</p> <ul style="list-style-type: none"> <li>• A written statement saying you want to cancel it,</li> <li>• Destroying it and all copies,</li> <li>• Telling at least two other people you want to cancel it,</li> <li>• Writing a new health care directive.</li> </ul>
--	---

<b>Distribution</b>	<p>Copies distributed to:</p> <p><input type="checkbox"/> Original (Your copy): _____</p> <p><input type="checkbox"/> Physician: _____</p> <p><input type="checkbox"/> Hospital: _____</p> <p><input type="checkbox"/> Healthcare agents: _____</p> <p><input type="checkbox"/> Other: _____</p>
---------------------	--