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PLEASE RESPOND TO: WAYZATA

HEALTH CARE DIRECTIVE

DRAFT FORM WITH SAMPLE RESPONSES

Dear Client:

You have expressed an interest in having our office assist you in drafting a document so that you can name persons who will make health care decisions for you if you are unable to do so. Additionally, you indicated a desire to make specific preferences or instructions regarding your health care known in advance so that your desires and beliefs regarding issues of life and death can be communicated even if you are unable to communicate for yourself.

Although the prior document for making such decisions was called the *Health Care Living Will*, the name of that document was changed by the Minnesota legislature in 1998 to the **HEALTH CARE DIRECTIVE**. The **HEALTH CARE DIRECTIVE** is only valid and effective when it is created and signed according to the requirements of the law. Your doctors are legally bound to follow your instructions, therefore it is important that you create a clear and definite statement regarding your desires and beliefs for your care.

The following is a draft form of the **HEALTH CARE DIRECTIVE** with sample responses included. The law does not require you to answer every question in this **HEALTH CARE DIRECTIVE**. In fact, if you leave all of the questions unanswered, you will be giving your agent the power to make *ALL* decisions regarding your care.

As you complete this draft form, you will see that sample responses have been provided. Those responses are merely a guide. You may use the sample responses, modify the sample responses, or respond to each subject in your own words in the blank space that has been provided. If you require more space for your answer, please use the back of the sheet. You can put as much or as little instruction for each questions as you desire. If you use a sample response, you may simply check the box in the place provided.

When you have completed the draft form of your **HEALTH CARE DIRECTIVE**, please date and sign the last page and return it to our office. We will put your draft **HEALTH CARE DIRECTIVE** in final form and will meet with you to sign the document and to put your instructions in place. If you have any questions, we recommend that you speak with your doctor. Additionally, you can contact our office at 952-475-1001 if you have any questions.

/s/ Eric R. Rousar

HEALTH CARE DIRECTIVE

I, _____, also known as _____, 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

A. 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 , _____, also known as _____, trust and appoint my _____ (*spouse, sibling, child, friend, etc.*), _____, to make health care decisions for me. This person is called my health care agent.

HEALTH CARE AGENT

Name of 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 my _____ (*spouse, sibling, child, friend, etc.*), _____, to be my health care agent instead.

ALTERNATE HEALTH CARE AGENT

Name of 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 Second Alternate Health Care Agent:** If my health care agent is not reasonably available, I trust and appoint my _____ (*spouse, sibling, child, friend, etc.*), _____, to be my health care agent instead.

SECOND ALTERNATE HEALTH CARE AGENT

Name of 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 Third Alternate Health Care Agent:** If my health care agent is not reasonably available, I trust and appoint my _____ (*spouse, sibling, child, friend, etc.*), _____, to be my health care agent instead.

THIRD ALTERNATE HEALTH CARE AGENT

Name of 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: _____
_____

B. 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 the 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:

☐ **Please follow my instructions listed in Part II, or**

_____

_____

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 limit on the powers, I can say it here:

☐ **Please follow my instructions listed in Part II, or**

_____

_____

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).

A. 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:

My goals for my health care:

☐ **a)** **I recognize I cannot exactly predict what might happen to me, but I instruct my agent and my health care providers to use this information to the best of their ability in making treatment decisions for me if I am unable to speak for myself. I understand that I will be provided medically appropriate life-supporting treatments UNLESS I DIRECT OTHERWISE.**

☐ **b)** **I want to live and die with personal dignity and autonomy.**

☐ **c)** **I want care and treatment that will make it possible to remain active as long as possible.**

☐ **d)** _____

_____

My fears about my health care:

☐ **a)** _____

_____

_____

My spiritual or religious beliefs and traditions:

☐ **a)** _____

_____

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

☐ **a)** **I feel it is the quality of life that is important. If I am comatose or in a persistent vegetative state, it is my sincere belief that I no longer have any quality of life and I am better off dead.**

☐ **b)** _____

_____

My thoughts about how my medical condition might affect my family:

☐ **a)** _____

_____

B. 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)

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

☐ **a)** **I want care and treatment that will make it possible to remain active as long as possible.**

☐ **b)** **I want relief of pain, comfort care, and treatment that will cure me or**

substantially relieve my condition, and will let me live and die with personal dignity and autonomy.

☐ **c)** _____

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

☐ **a)** **If I am in a terminal condition or if I am dying, I would WANT all available, appropriate and medically indicated life-supporting treatment.**

☐ **b)** **I would WANT artificial nutrition and hydration to be continued**

☐ **c)** **I would WANT medications that will bring me comfort and pain relief from my symptoms.**

☐ **d)** **If I am in a terminal condition or if I am dying, I direct that all artificial life support be DISCONTINUED. I direct that my dying process NOT be extended by any means, including the use of cardiopulmonary resuscitation and artificial ventilation.**

☐ **e)** **You may start a TRIAL OF THERAPY or treatment to be given for a reasonable time to be determined by my agent and my physicians. This therapy may include all treatments necessary to help make me more comfortable or to otherwise benefit me. Should it be determined that such treatments are futile, I would then want such treatments and all artificial life supports DISCONTINUED, even if this will result in my death.**

☐ **f)** **I specifically reject artificial nutrition and hydration of any kind if I am in a terminal condition.**

☐ **g)** **I want my agent to decide whether I should have artificial nutrition and hydration if I am in a terminal condition.**

☐ **h)** **In the event I am pregnant,** _____

_____

☐ **i)** **I don't want treatment given just to make my family and doctor and nurses feel better.**

☐ **j)** _____

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

☐ **a)** **If I am irreversibly unconscious, comatose, or vegetative, I would WANT all appropriate and medically indicated life-supporting treatment or procedures.**

☐ **b)** **I would WANT artificial nutrition and hydration to be continued, along with medications that will bring me comfort and relief from my symptoms.**

☐ **c)** **If I am irreversibly unconscious, comatose, or vegetative, I direct that all artificial life support be DISCONTINUED, but that appropriate pain relief medications be provided.**

☐ **d)** **You may start a TRIAL OF THERAPY or treatment to be given for a reasonable time to be determined by my agent and my physicians. This therapy may include all treatments necessary to restore me to a reasonable quality of life, to help make me more comfortable or to otherwise benefit me. Should it be determined that such treatments are futile, I would then want such treatments and all artificial life supports DISCONTINUED, even if this will result in my death.**

☐ **e)** **I feel it is the quality of life that is important. If I am comatose or in a persistent vegetative state, it is my sincere belief that I no longer have any quality of life and I am better off dead.**

☐ **f)** **I specifically reject artificial nutrition and hydration of any kind if I am irreversibly unconscious, comatose or vegetative.**

☐ **g)** **I want my agent to decide whether I should have artificial nutrition and hydration if I am irreversibly unconscious, comatose or vegetative.**

☐ **h)** **In the event I am pregnant,** _____

_____

☐ **i)** _____

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

☐ **a)** _____

_____

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

☐ **a)** **I want pain control and provision for comfort.**

☐ **b)** **I want to be given comfort care and enough pain medication to keep me free from pain, even if this should hasten my death.**

☐ **c)** **I don't want to be kept sedated (drugged) so I can't communicate with my family. I am willing to bear some pain if I know what is going on.**

☐ **d)** **I don't want treatment given just to make my family and doctor and nurses feel better.**

☐ **e)** _____

_____

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

☐ **a)** **I do not want any life-sustaining treatment or procedures that will prolong my dying.**

☐ **b)** **I do not want treatment that promises possible prolongation of life without likelihood of substantial improvement in functional capacity.**

☐ **c)** **If I am terminally ill, comatose or vegetative, I DO NOT WANT cardiopulmonary resuscitation ("CPR") and I would direct my doctor to write "DNR" (do not resuscitate), "DNI" (do not intubate), and "No CPR" in my medical record.**

☐ **d)** _____

Who I would like to be my doctor:

☐ **a)** **Dr.** _____

_____

Where I would like to receive health care:

☐ **a)** **I wish to receive home health care if at all possible.**

☐ **b)** **If necessary, I want to receive medical treatment at a hospital.**

Which one? _____

☐ **c)** **If necessary, I want to receive medical treatment & long term care at a nursing home.**

Which one? _____

☐ **d)** **If necessary, I want to receive medical treatment from other health care providers.**

Which one(s)? _____

☐ **e)** _____

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

☐ **a)** **See my answers above.**

☐ **b)** **I prefer not to be sent to a hospital to die.**

☐ **c)** **If I am dying and if a choice is possible and reasonable, I would prefer to receive my care:**

- ☐ **At home**
- ☐ **At a hospital. Which one?** _____
- ☐ **At a nursing home. Which one?** _____
- ☐ **Through a hospice. Which one?** _____
- ☐ **From other health care providers. Which one(s)?** _____

_____

☐ **d)** _____

My wishes about donating parts of my body when I die:

☐ **a)** **I wish to donate any needed and useable tissues, organs, or other body parts after I die.**

☐ **b)** **I only wish to donate the following body parts:** _____

_____

☐ **c)** **Limitations or special wishes I have:** _____

_____

☐ **d)** **I understand that to become an organ donor, I must be declared brain dead. My organ function may be maintained artificially on a breathing machine, (*i.e., artificial ventilation*), so that my organs can be removed.**

☐ **e)** **I (have) (have not) [*PLEASE CIRCLE ONE*] agreed in another document or on another form to donate some or all of my organs when I die.**

☐ **f)** **I DO NOT WISH to become an organ donor upon my death.**

☐ **g)** _____

My wishes about what happens to my body when I die (cremation, burial):

☐ **a)** **The following are my burial instructions . . .**

_____

_____

_____

☐ **b)** **I wish to be cremated . . .**

_____

_____

If I have named two or more agents to act simultaneously:

☐ **a)** **My agents may act independently.**

☐ **b)** **My agents must act jointly.**

If there is a petition for the appointment of a guardian or conservator to have authority with respect to decisions concerning life-sustaining procedures or other health care for me:

☐ **a)** **I hereby nominate, pursuant to the authority given to me under Minnesota Statutes, the agent(s) designated herein for appointment by the court as guardian or conservator of my person. I ask that the guardian/conservator be given authority to make such health care decisions regarding my person as may be permitted under applicable Minnesota law.**

Any other things:

☐ **a)** **I give full authority to my agent to decide any issues not clarified in this document.**

☐ **b)** **I hereby revoke all Living Wills, Health Care Declarations, Durable Powers of Attorney for Health Care and other written advance health care directives I have signed in the past.**

☐ **c)** _____

_____

PART III: MAKING THE DOCUMENT LEGAL

*Although, this is **ONLY** the **draft** Health Care Directive, please sign and date this page so that we can verify that these are your desires.*

I, _____, born on _____, am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

DATED: _____

SIGNED: _____