HealthPartners®

Minnesota Health Care Directive

Contents

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Minnesota Health Care Directive: Instructions

A health care directive is a written legal document that informs others of your health care preferences and wishes when you are unable to communicate or make your own health care choices. The following instructions are for the HealthPartners Health Care Directive form. **Please read these instructions before you complete your health care directive.**

About your health care directive

- Your health care directive allows you to:
  - » Appoint someone to partner with your clinicians to make health care decisions for you when you are unable to speak for yourself.
  - » Give health care instructions to guide others in making health care decisions for you when you are unable to speak for yourself.
- For this to be a legal document, you must complete:
  - » Section A: My name and other information,
  - » Section B: My heath care agent and/or Section E: My health care instructions, choices and preferences, and
  - » Section G: Making the document legal.
- Section D is optional, but we recommend you complete it. The more information you put in your health care directive, the better your care team, family and friends will understand your wishes.
- You do not need to include written instructions in Section E, but it helps to do so. Without written instructions, your health care agent will make decisions based on your spoken wishes, or in your best interest if your wishes are not known.
- Tell your health care agent or agents you have chosen them. Make sure they are willing and able to do this important job for you. Give them a copy of your health care directive.
- Once you fill out a new health care directive, please destroy any other versions. Older health care directives will no longer be valid.

Section A: My name and other information

In Section A of the health care directive, you provide your full name, date of birth, address and phone number.

Section B: My health care agent

In Section B of the health care directive, you name one or more health care agents. A health care agent is someone who communicates your wishes and health care decisions when you cannot do so:

- Because of illness or injury.
- If your health care team determines that you cannot make your own health care decisions.

Your health care agent must:

- Be age 18 or older.
- Act in good faith.
- Follow your health care instructions.
- Make decisions in your best interest.

Health care agents are people you trust to make health care decisions for you. Your health care agents may be family or friends. They cannot be a health care provider or employee of a health care provider giving direct care to you unless:

- You are related to that person by blood or marriage, registered domestic partnership or adoption.
- You provide a clear reason in your health care directive document for why you want that person to serve as your agent.

In Minnesota, you are allowed to have multiple health care agents act together to make decisions, called joint health care agents. Be aware that having joint health care agents can be challenging. If you decide to have joint health care agents, be sure to provide information on:

- How they will resolve differences they may have about your care.
- Whether they can make decisions independently of each another.

Section C: My health care agents' powers

When you cannot communicate for yourself, your health care agent has the power to:

- Agree to, refuse, or cancel decisions about your health care—even if treatment has begun (such as tests, medications, surgery and tube feedings).
- Interpret the instructions in your health care directive while keeping your preferences, values and beliefs in mind.
- Review and release your medical records as needed for your health care (unless limited by you).
- Arrange for my healthcare and treatment in Minnesota or other state or location the health care agent thinks is appropriate.
- Decide which clinicians and organizations provide your health care.
- If specifically authorized, make decisions about care of your body after death.
- Make mental health treatment decisions, including decisions related to the use of antipsychotic medications. Antipsychotics, previously called neuroleptics, are a class of medication used to treat a variety of mental health conditions, such as schizophrenia, schizoaffective disorder, psychotic disorders and bipolar disorder. They can also be used to help treat certain kinds of depression or to help manage acute agitation.

Section D: My hopes and wishes

In Section D, you answer questions about what living well looks like for you—and what your thoughts and feelings are about care at end of life. Your answers will help your care team and family follow your wishes as best they can.

Section E: My health care instructions

In Section E, you provide your choices and preferences about:

- Cardiopulmonary resuscitation (CPR)—whether you want CPR attempted. **Your decisions about CPR are based on your current health today.** Please see the box on page 3 for more information on CPR.
- Treatments that may prolong life—if your health changes in the future and you are not expected to recover.

In Section E, you also have space to write additional comments to your care team. If you run out of space, initial the box and attach additional documents with your health care directive.

Section F: Other considerations

In Section F, you note your spiritual affiliation (if any) and document your wishes on the care of your body after death (for example, autopsy, organ or tissue donation, cremation or burial, and wishes you may have for a memorial service).

The last part of Section F includes space to write other comments or directions for your care team. If you run out of space, initial the box at the bottom of the page and attach additional documents with your health care directive.

Section G: Legal authority

After completing your health care directive, be sure to sign and date it in the presence of 2 witnesses or a notary public. A notary public is a person who has the authority to formally witness and certify signatures on legal documents, such as a health care directive.

Information about CPR

Cardiopulmonary resuscitation (CPR) is a treatment used to try and restore heart rhythm and breathing when they have stopped. CPR may include forceful pushing on the chest to make the blood circulate, medications, electrical shocks, a breathing tube, and hospitalization. CPR does not always work. Recovery from CPR can be painful and difficult. CPR doesn't work as well for people who have chronic (long-term) diseases or impaired functioning, or both.

The choices you make about attempted CPR are based on your health today. You or your health care agent should discuss CPR with your health care team if your health changes in the future, such as:

- Having an incurable illness or injury from which you are dying.
- Having no reasonable chance of survival if your heart or breathing stops.
- Having little chance of long-term survival if your heart or breathing stops and CPR would cause significant suffering.

If you choose not to have attempted CPR, you will still get all other medical care you need. Please speak with your clinician if you have questions about the effectiveness of attempted CPR in your situation.

Next Steps

After completing your health care directive, be sure to do the following:

- Give your health care agent or agents a copy of this completed health care directive. Discuss your health care choices and the directive from time to time to keep communication open.
- Talk to other family and close friends who might be involved if you have a serious illness or injury. This will help them to know who your health care agent is and what your health care choices are.
- Keep a copy of your health care directive where you and others can easily find it.
- Give a copy of this completed health care directive to your doctor and care team. Ask that your health care directive be placed in your medical record.
- Review your health care directive every time you have changes in your health status or life situation (such as a death of loved one or divorce).

Resources

Additional resources can be found by searching "advance directive" at healthpartners.com.

Minnesota Health Care Directive

HDIR

Please review the Minnesota Health Care Directive Instructions before completing this document.
I understand that for this to be a legal document, I must complete: (1) Section A: My name and other information, (2) Section B: My health care agent and/or Section E: My health care instructions, **and** (3) Section G: Making the document legal.

Section A: My name and other information

My full name _____ My date of birth _____

My address _____

My phone numbers (home) _____ (cell) _____

☐ My initials here indicate a professional language interpreter helped me complete this document.

Section B: My health care agent

My primary (main) health care agent is:

Full name _____ Relationship _____

Phone numbers (H) _____ (C) _____ (W) _____

City, state _____

If my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate health care agent.

My alternate health care agent is:

Full name _____ Relationship _____

Phone numbers (H) _____ (C) _____ (W) _____

City, state _____

My second alternate health care agent is:

Full name _____ Relationship _____

Phone numbers (H) _____ (C) _____ (W) _____

City, state _____

☐ My initials here indicate I attached additional pages to this health care directive that identify additional primary and/or alternate health care agents. I included instructions as to how the agents will resolve care decision differences and whether they must make all care decisions together or if they may act independent of each other.

Section C: My health care agent powers

When I am unable to speak for myself, my health care agent may: (1) consent, refuse, withdraw care, treatment, service or procedure; (2) review and release my health care records; (3) choose my health care providers; and (4) choose where I live. I understand my health care agent cannot request care that is outside standard medical practice.

Additional powers of my health care agent. My initials below authorize my health care agent to:

☐ Continue as my health care agent even if our marriage or domestic partnership is legally ending or has been ended.

☐ Make health care decisions – when I choose – even though I am able to speak for myself.

☐ Make mental health treatment decisions including neuroleptic/antipsychotic medications.

☐ If I am pregnant, determine whether to attempt to continue my pregnancy to delivery.

Limits to my health care agent's powers _____

Section D: My hopes and wishes

How do you define a good quality of life for yourself today? What does living well look like to you?

What would be an unacceptable quality of life (for instance, if you couldn't do certain things)?

My thoughts about receiving or not receiving specific medical treatments, if any:

My thoughts and feelings about the care I would want at end of life:

☐ My initials here indicate additional pages are attached.

Section E: My health care instructions, choices and preferences

I ask my health care agent to communicate my choices to my health care team. I have initialed one box below for the option I prefer for each situation.

1. Cardiopulmonary resuscitation (CPR)

See the Health Care Directive Instructions document for more detailed information about CPR. Based on my health today:

☐ I want CPR attempted when my heart or breathing stops.

or

☐ I want CPR attempted when my heart or breathing stops, based on my current state of health. If my health changes in the future and I have no reasonable chance of recovery then my agent (if one appointed) will discuss attempted CPR with my health care team, based on earlier conversations or statements I have written in Section D: My hopes and wishes.

or

☐ I do not want CPR attempted when my heart or breathing stops. I understand if I choose this option, I should see my clinician about completing a Provider Orders for Life-Sustaining Treatment (POLST) form.

Section E: My health care instructions, choices and preferences *continued*

2. Treatments that may prolong my life – *initial one box*

With any choice below, I understand that I will continue to receive all pain and comfort medicines and be offered food and liquids by mouth if I am able to swallow. If the time comes that I can no longer speak for myself and my health care team and agent believe I will not recover my ability to think, communicate or know who I am, I want:

☐ **All medically reasonable treatments available and agreed upon by my health care team.** This includes but is not limited to tube feedings, IV (intravenous) fluids, ventilator (breathing machine), and antibiotics. I want treatments to continue until such treatments are harmful or no longer helpful.

or

☐ **To stop or not start treatments that may extend my life.** This includes but is not limited to tube feedings, IV (intravenous) fluids, ventilator (breathing machine), and antibiotics.

Comments or directions regarding treatments that may prolong my life

Use this space to write any additional instructions or messages regarding treatments that may prolong my life (for example, trying a specific treatment for a limited time):

Section F: Other considerations (use additional pages if needed)

Spiritual affiliation

☐ I identify with the _____ spiritual/religious tradition. I am a member of the spiritual/religious community, _____ located in (city) _____.

☐ I do not identify with a spiritual/religious tradition at this time or wish to report it here.

Organ donation – *initial one box*

☐ After my death, I want to donate my eyes, tissues and/or organs, if able. My health care agent, according to Minnesota Law, may start and continue interventions needed to maintain my organs, tissues and eyes until donation has been completed. My specific wishes (if any) are:

_____

or

☐ I do not want to donate my eyes, tissues and/or organs.

Decisions about my body after death

☐ My initials here indicate my health care agent has the power to make decisions about my body when I die (autopsy, burial, cremation, funeral).

My preferences for funeral/memorial service, music, rituals, funeral home include:

Comments or directions to my health care team

☐ My initials here indicate additional pages are attached.

Section G: Making the document legal

NOTE: Under Minnesota law, either 2 witnesses or a notary public must verify your signature and the date. Your witnesses or notary public cannot be named as your primary or alternate health care agent.

My Signature

I have made this document willingly, I am thinking clearly. This document states my wishes about my future health care decisions.

Signature: _____ ***Print form prior to signing in presence of 2 witnesses or Notary Public.***

If I cannot physically sign my name, I ask the following person to sign for me:

Printed name: _____

Signature (of person asked to sign): _____ **Date:** _____

Statement of Witnesses

This document was signed or verified in my presence. I certify that I am at least 18 years of age, and I am not appointed as a primary or alternate health care agent in this document.

If I am a health care provider or an employee of a health care provider giving direct care to the person listed above, I must initial this line: _____ . Only one witness may be a provider or an employee of the provider giving direct care on the date this document is signed.

Witness 1

Signature _____

Date _____

Print full name _____

Phone (optional) _____

Witness 2

Signature _____

Date _____

Print full name _____

Phone (optional) _____

or

Notary Public

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

Signature of notary:

Notary stamp:

My commission expires (date): _____