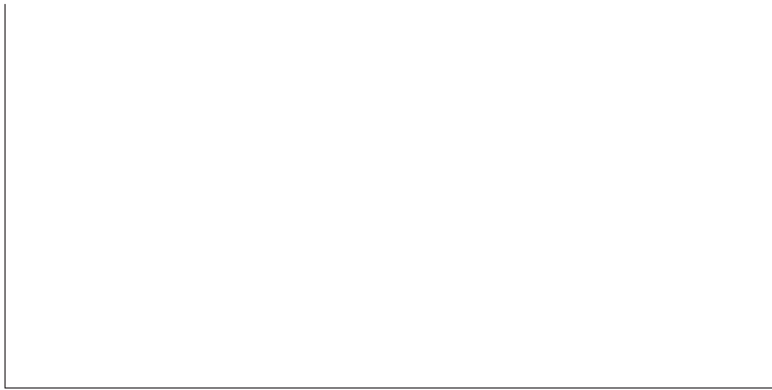

Minnesota Health Care Directive

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.

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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.

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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: ______________________________ **Date:** ____________

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): ______________________