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Health Care Directive Worksheet

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Purpose of a Health Care Directive:

A health care directive is a document allowed under Minnesota law that gives you the opportunity to state in writing your wishes and beliefs about health care and to appoint someone to make your wishes regarding health known to others. Your health care directive is only used when you are unable to communicate your health care wishes.

Health care directives are also known as living wills. However, it is important to know that a health care directive DOES NOT take the place of a Last Will and Testament or other estate planning tools.

This worksheet will help us gather information about your health care needs and desires to construct your personal health care directive. If you desire, we will also attach this worksheet to your formal health care directive to further aid your health care agent and providers in making decisions regarding your care.

Step One: General Information about you

First Name: _____

Middle Name: _____

Last Name: _____

Address: _____

_____

Phone: _____

Birthdate: _____

Step Two: Determine the Scope of your Health Care Directive

(Check ONE of the boxes below)

- ☐ I would like my health care directive to ONLY outline my wishes.
- ☐ I would like my health care directive to ONLY name a health care agent.
- ☐ I would like my health care directive to outline my wishes AND name a health care agent (most choose this option).

Step Three: Name a Health Care Agent

Name: _____

Address: _____

Phone: _____

Relationship: _____

Alternative Health Care Agent (if desired), to serve in the event your nominated health care agent is unwilling or unable to serve.

Name: _____

Address: _____

Phone: _____

Relationship: _____

If you have designated more than one agent, choose one below:

☐ My Co-Healthcare Agents may act independently; or

☐ My Co-Healthcare Agents must act unanimously to the extent that they can be contacted in a time frame that is consistent with the urgency of my health care needs, provided however, if my Co-Healthcare Agents fail to agree, then I appoint the below person to make decisions for me:

Name: _____

Address: _____

Phone: _____

Relationship: _____

Step Four: Your Health Care Goals and Desires

Check the statements below which best reflect your personal health care goals. You may choose more than one answer. If you are undecided, note that in the comments section.

1) <u>What would you like to have happen with your body after you die?</u>

☐ Cremation

☐ Burial

☐ Comments (Please include information relating to a Funeral Trust or Prepaid Funeral Plan, if you have one): _____

_____

_____

2) Life Support Treatment

- ☐ I want all life support treatments so long as there is a reasonable chance of my full recovery.
- ☐ I want life support treatments even if I may have some physical limitations, but can still mentally relate to my loved ones.
- ☐ I do not want life support if I am in a vegetative state or paralyzed from the neck down.
- ☐ I want life support treatments regardless of the effect it will have on me physically or mentally.
- ☐ I do not want life support if it will result in a mental condition that would severely limit my ability to relate to my loved ones.
- ☐ I do not want life support if it will result in permanent brain damage.
- ☐ I do not want life support if I am suffering from a terminal illness with no reasonable chance of recovery.
- ☐ I do not want life support treatment under any circumstances.
- ☐ Comments: _____

_____

_____

3) Where you Want to Live

- ☐ I want to remain in my own home as long as I live.
- ☐ I accept and desire Hospice care, when it is appropriate.
- ☐ If possible, I would like to die in my own home.
- ☐ Comments: _____

_____

_____

4) Certain Medical Treatments

Respirator

- ☐ I accept the use of a respirator when there is a reasonable chance of my full recovery.
- ☐ I accept the use of a respirator on a temporary basis to assist with my recovery.
- ☐ I accept the use of a respirator under all circumstances even if it is used to keep me alive and without it, I might die.
- ☐ I do not accept the use of a respirator of its sole purpose is to keep me alive and that there is no reasonable chance that I will be able to live without a respirator. I understand that refusing a respirator under these circumstances may hasten my death.
- ☐ I do not accept the use of a respirator under any circumstances.
- ☐ Comments: _____

_____

_____

Pain Relief

☐ I desire that my doctors provide me with pain relief to keep me as comfortable as possible, even if it would affect my alertness.

☐ I desire that my doctors provide me with pain relief to keep me as comfortable as possible, even if it could shorten my life.

☐ I do not want pain relief treatment that would affect my alertness.

☐ I do not want pain relief treatment that could shorten my life.

☐ Comments: _____

_____

_____

Organ Donation

☐ I would like my organs to be donated upon my death.

☐ I do not want my organs donated upon my death.

☐ Comments: _____

_____

_____

Blood Transfusions

☐ I accept blood or plasma transfusions whenever necessary.

☐ I do not accept any blood transfusions.

☐ I accept plasma transfusions only.

☐ Comments: _____

_____

_____

Resuscitation:

☐ I want health care providers to attempt to resuscitate me in the event my heart and lungs stop functioning.

☐ I DO NOT want to be resuscitated in the event my heart and lungs stop functioning.

☐ Comments: _____

_____

_____

Feeding Tubes

☐ I do not want feeding tubes under any circumstances, even if refusing such treatment may shorten my life.

☐ I accept feeding tubes for a period of time if there is a reasonable chance I will recover and be able to accept food and drink by mouth.

☐ I accept feeding tubes for an indefinite period of time even if there is no reasonable chance I will recover and be able to accept food and drink by mouth.

☐ Comments: _____

_____

_____

****The following pages are optional additions to your Health Care Directive.****
Please complete any sections that you would like to add.

Step 5: Optional Sections

Visitation Rights

☐ I would like only immediate (nuclear) family to be able to visit me.
☐ I would like friends and family to be able to visit me.
☐ I specifically would like _____ to be able to visit me.
☐ I specifically would NOT like _____ to be able to visit me.
☐ Comments: _____
_____
_____

Mental Health Treatments

A competent adult may make a declaration of preferences or instructions regarding intrusive mental health treatment, including consent or refusal to such treatments.

☐ Check this box if you would like to include the following additional language: "Whenever I am unable to decide for myself, I designate my health care agent as proxy to make decisions about intrusive mental health treatment within the meaning of Minn. Stat. § 253B.03, subd. 6d, including electroconvulsive therapy and administration of psychotropic medications as defined by Minn. Stat. § 245D.02, subd. 27: "Psychotropic medication" means any medication prescribed to treat the symptoms of mental illness that affect thought processes, mood, sleep, or behavior. The major classes of psychotropic medication or antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior."
☐ Comments: _____
_____
_____

Step 6: Optional Narrative Statement

If you do not select one of the options below, a standard narrative statement will be used.

1) Option 1

My Goals for my Health Care:

☐ To preserve my self-determination, well-being, and dignity, and to avoid the unnecessary prolongation of my life, pain, or suffering if there is no reasonable hope for my recovery.
☐ To receive all reasonable medical treatments that may improve my condition or prolong my life as long as I am able to care for myself or have realistic hopes of regaining my ability to care for myself.

- ☐ To receive any medical procedures, nutrition, and hydration necessary to prolong my life to the greatest extent possible, regardless of my physical or mental condition, chance of recovery, likelihood of suffering, or expense.
- ☐ To stop or withhold any life sustaining procedures if I have any incurable injury, disease, or illness, with the exception of those procedures necessary for my comfort and pain alleviation.
- ☐ To stop or withhold any life sustaining procedures if I am in a permanent and irreversible comatose state, with the exception of those procedures necessary for my comfort or pain alleviation.
- ☐ To stop or withhold any life sustaining procedure if the burdens of the proposed treatment or procedure outweigh its expected benefits or would result in my mere biological existence, with the exception of those procedures necessary for my comfort or pain alleviation.
- ☐ Comments: _____
  _____
  _____

My Fears About My Health Care:

- ☐ Having no reasonable hope for recovery, being unable to communicate my wishes, and being kept alive by artificial means for a long period of time (such as months, years, or decades).
- ☐ The indignities of deterioration, dependence, and hopeless pain.
- ☐ The emotional burden that such a degrading existence would put in my family and friends.
- ☐ Comments: _____
  _____
  _____

My Hopes about End-of-Life Care:

- ☐ I hope my end-of-life care will prioritize my self-determination, well-being, and dignity.
- ☐ I hope my end-of-life care will prioritize minimizing my pain and suffering.
- ☐ I hope my end-of-life care will prioritize lessening the emotional burden on my loved ones.
- ☐ I hope my end-of-life care will prioritize prolonging my life to the greatest extent possible.
- ☐ Comments: _____
  _____
  _____

My Spiritual or Religious Beliefs Are:

- ☐ I have no comments about my personal values because I believe my health care agent(s) know me well enough to apply my wishes regarding health care in most circumstances.

☐ I am of the _____ faith and am a member of _____ faith community in the city of _____. Please notify them of my death and arrange for them to provide my funeral/memorial/burial.

☐ Comments: _____
_____
_____

My Beliefs About When Life Would No Longer be Worth Living:

☐ When I can no longer preserve my self-determination, well-being, or dignity due to my medical condition.

☐ When I have an incurable and terminal injury, disease, or illness and any medical treatment will only serve to prolong the moment of my death.

☐ When I am in a permanent, irreversible comatose state, devoid of cognitive function and unable to interact with my environment.

☐ When the burdens of my proposed medical treatment outweigh the benefits to myself.

☐ I do not believe there is a point when life would no longer be worth living.

☐ Comments: _____
_____
_____

My Thoughts About How My Medical Condition Might Affect My Family:

☐ Having no reasonable hope for recovery, being unable to communicate my wishes, and being kept alive by artificial means for a long period of time would place a terrible emotional burden on my family and friends.

☐ My family and friends understand and support my decision to prolong my life to the greatest extent possible, regardless of my physical or mental condition, chance of recovery, likelihood of suffering, or expense.

☐ Comments: _____
_____
_____

2) Option 2

Check this box if you would like the standard narrative used:

☐ My goals for my health care are to provide comfort, control pain, and provide treatment that may substantially improve my condition.

I do not fear death itself as much as the indignities of deterioration, dependence, and hopeless pain. I therefore ask that medication be mercifully administrated to me to alleviate suffering even though this may hasten the moment of death.

Because of my belief in life after death, I understand that death is not an end but just another stop on my journey. My wishes concerning my funeral or burial have been communicated to both my family and my health care agent, and I ask that they be followed.

I understand that my medical condition may have a significant emotional effect on my family. My hope is that by setting forth my health care goals and desires in this document, my family will know that I make this health care declaration to spare them unnecessary emotional pain and agony.

If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures."

☐ Comments or changes: _____

_____

_____