OLMSTED MEDICAL CENTER

Healthcare Directive

Chart ID/MRN: _____

I, _____, understand this document allows me to do one or both of the following:

PART I: Name another person (called the healthcare agent) to make healthcare decisions for me if I am unable to decide or speak for myself. My healthcare agent must make healthcare decisions for me based on the instructions I provide in this document (Part III), if any, the wishes I have made known to him/her, or must act in my best interest if I have not made my healthcare wishes known.

AND/OR

PART III: Give healthcare instructions to guide others making healthcare decisions for me. If I have named a healthcare agent, these instructions are to be used by the agent. These instructions may also be used by my healthcare providers, others assisting with my healthcare and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTHCARE AGENT

This is who I want to make healthcare 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 healthcare 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 trust and appoint

_____ to make healthcare decisions for me. This person is called my healthcare agent.

Relationship of my healthcare agent to me: _____

Telephone number of my healthcare agent: _____

Address of my healthcare agent: _____

_____

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTHCARE AGENT: If my healthcare agent is not reasonably available, I trust and appoint _____ to be my healthcare agent instead.

Relationship of my alternate healthcare agent to me: _____

Telephone number of my alternate healthcare agent: _____

Address of my alternate healthcare agent: _____

_____

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This is what I want my healthcare agent to be able to do if I am unable to decide or speak for myself. (I know I can change these choices.)

My healthcare agent is automatically given the powers listed below in (A) through (D).

My healthcare agent must follow my healthcare instructions in this document or any other instructions I have given to my agent. If I have not given healthcare instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my healthcare agent has the power to:

(A) Make any healthcare decisions 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 healthcare that is keeping me or might keep me alive and deciding about intrusive mental health treatment.

(B) Choose my healthcare providers.

(C) Choose where I live and receive care and support when those choices relate to my healthcare 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 healthcare 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: _____

_____

My healthcare 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 my organs 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 healthcare agent's powers or limits on the powers, I can say it here:

_____

_____

PART II: HEALTHCARE INSTRUCTIONS WORKSHEET
MY HEALTHCARE GOALS

Having a sense of what is important to you can help your decision-makers make healthcare decisions under different and complex circumstances. Read each statement below and on a scale of "0" to "4", rate how important each of the healthcare goals are to you. In this case, "4" means "Extremely Important" and "0" means "Not Important At All". Remember reasonable medical care should always include maintaining a person's comfort, hygiene, and human dignity.

HEALTHCARE GOALS	Not Important		Somewhat Important		Extremely Important
	0	1	2	3	4
How Important Is Pain Control?	☐	☐	☐	☐	☐
❖ Being as comfortable and free from pain as possible	☐	☐	☐	☐	☐
❖ Having pain controlled, even if my ability to think clearly is reduced	☐	☐	☐	☐	☐
❖ Having pain controlled, even if it shortens my life.	☐	☐	☐	☐	☐
How Important Is the Use of Life Prolonging Treatment When:					
❖ I have a reasonable chance of recovering both physically and mentally (50/50)	☐	☐	☐	☐	☐
❖ I have some physical limitations but can socially relate to those I care about	☐	☐	☐	☐	☐
❖ I can live a longer life no matter what my physical or mental health	☐	☐	☐	☐	☐
❖ I have little or no chance of doing everyday activities I enjoy	☐	☐	☐	☐	☐
❖ I have a terminal illness and treatment will only prolong when I die	☐	☐	☐	☐	☐
❖ I have severe and permanent brain injury and there is little chance of regaining consciousness	☐	☐	☐	☐	☐
❖ I have severe dementia or confusion and my condition will only get worse.	☐	☐	☐	☐	☐
Importance of Finances and Healthcare					
❖ Having my wishes followed regardless of whether or not my finances are exhausted	☐	☐	☐	☐	☐
❖ Not being a financial burden to those around me	☐	☐	☐	☐	☐
❖ Not having my healthcare costs affect the financial situations of those I care about	☐	☐	☐	☐	☐

I also want my decision-makers to know the following things are important to me when receiving healthcare: _____

_____

MY MEDICAL TREATMENT PREFERENCES

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a healthcare professional to make sure you understand what they might mean for you, given your current as well as future health conditions.

Medical Procedure	When It Is Used and Its Effects	My Feeling About This Procedure
Ventilator; Respirator A breathing machine A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure.	When you cannot breathe on your own You cannot talk or eat by mouth on this machine.	
Nutrition support and hydration	When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely. Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins.	
Cardiopulmonary Resuscitation (CPR) A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.	Actions to make your heart and lungs start if they stop, including pounding on your chest, electric shocks, medications, and a tube in your throat.	
Dialysis	A mechanical means of cleaning the blood when kidneys are not working.	

PART III: HEALTHCARE INSTRUCTIONS

(NOTE: Complete this Part III if you wish to give healthcare instructions. If you appointed an agent in Part I, completing this Part III is optional but would be very helpful to your agent. However, if you choose not to appoint an agent in Part I, you **must** complete some or all of this Part III if you wish to make a valid healthcare directive.)

These are instructions for my healthcare when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs). These are my beliefs and values about my healthcare. (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 healthcare:

My goals for my healthcare: _____

_____

My fears about my healthcare: _____

_____

My spiritual or religious beliefs and traditions: _____

_____

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

_____

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

_____

This is what I want and do not want for my healthcare. (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.

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I have these views about my healthcare 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:

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

If I was permanently unconscious and unable to speak for myself, I would want:

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

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

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

Who I would like to be my healthcare provider:

Where I would like to receive healthcare:

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

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

_____

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

_____

_____

Any other things: _____

PART IV: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) **or** witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

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

My signature: _____ Date signed: _____

Date of birth: _____ Address: _____

_____

If I cannot sign my name, I can ask someone to sign this document for me.

_____

(Signature of the person who I asked to sign this document for me.)

_____

(Printed name of the person who I asked to sign this document for me.)

Option 1: Notary Public

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

Signature of Notary: _____

(Notary Stamp)

Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a healthcare provider or an employee of a healthcare provider giving direct care on the day I sign this document.

Witness One:

(i) In my presence on _____ (date), _____ (patient name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
(ii) I am at least 18 years of age.
(iii) I am not named as a healthcare agent or an alternate healthcare agent in this document.
(iv) If I am a healthcare provider or an employee of a healthcare provider giving direct care to the person listed above in (i), I must initial this box: { }

I certify that the information in (i) through (iv) is true and correct.

_____
(Printed Name of Witness One)

_____
(Signature of Witness One)

Address _____

Witness Two:

(i) In my presence on _____ (date), _____ (patient name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.
(ii) I am at least 18 years of age.
(iii) I am not named as a healthcare agent or an alternate healthcare agent in this document.
(iv) If I am a healthcare provider or an employee of a healthcare provider giving direct care to the person listed above in (i), I must initial this box: { }

I certify that the information in (i) through (iv) is true and correct.

_____
(Printed Name of Witness Two)

_____
(Signature of Witness Two)

Address _____

REMINDER: Keep this **original** document with your personal papers in a safe place (not in a safe deposit box). Give signed **copies** to your healthcare providers, family, close friends, healthcare agent, and alternate healthcare agent. Make sure your healthcare provider is willing to follow your wishes. This document should be part of your medical record at your healthcare provider's office and at the hospital, home care agency, hospice, or nursing facility where you receive care.

Translated Versions – Consent – Healthcare Directive
English – 1083005 Spanish – 1090305 Somali – 1110808