

# HEALTH CARE DIRECTIVES

**A guide to help you consider and  
choose the most appropriate  
medical treatment based on your  
personal needs and beliefs.**



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## **INTRODUCTION**

In Minnesota, there are two types of health care directives:

- Health Care Directive
- Guardianship or Conservatorship

A health care directive is a written direction given in advance about the kinds of health care you would or would not want. Health care providers will use these directions if you cannot communicate your decisions to them.

This guide will discuss the health care directive. If you do not have a health care directive, no assumption will be made as to what care you would or would not have wanted. Your physician will consult with your family or someone who knows you well about health care decisions if you are unable to speak for yourself.

## **HEALTH CARE DIRECTIVES AVAILABLE IN MINNESOTA**

### **Health Care Directive**

The 1998 Minnesota Legislature created the health care directive. A health care directive can include appointment of a health care agent and/or health instructions and apply, whether or not you are terminally ill, whenever you specify it should take effect or whenever you are unable to make and communicate health care decisions. The health care directive may authorize a health care agent to make health care decisions for you even though you retain decision-making capacity.

A health care directive also may include information on funeral directives, anatomical gifts, intrusive mental health care, commitment and guardianship. A health care directive is presumed to remain in effect until you modify or revoke it, absent clear and convincing evidence to the contrary. If you are pregnant, the health care provider is required to presume that you want the necessary health care to sustain you and your fetus' lives, regardless of what your health care directive states.

### **Guardianship or Conservatorship**

If you are incapacitated and cannot handle your own financial or personal decisions, a court may grant a guardian or conservator. Consult your personal attorney for more information.

## **PERSONAL REFLECTION AND DISCUSSION – VALUES AND BELIEFS**

Before you complete a health care directive, it is important to consider your values and beliefs about life and death. Your responses to the following statements and questions will help you complete a health care directive. We encourage you to discuss your responses with your physician and the other important people in your life.

1. Which of the following two statements best reflect my values and beliefs?
  - I want to live as long as possible, by whatever means, regardless of my quality of life.
  - I want to preserve a good quality of life even if this means that I may not live as long.
2. To me, quality of life means ...
3. What makes life worth living for me?
4. The most important goals of medical treatment for me are ...
5. How do I feel about medical treatments which can prolong life but not heal an irreversible condition or incurable illness?
6. Does suffering have any worthwhile purpose for my life?
7. What fears do I have about illness or disability? About dying?
8. What will be important to me as I am dying (e.g., no pain, environment, physical comfort, etc.)?
9. Who is important to me and do I want them with me, if possible, when I am dying?
10. How does my faith influence the way I would like to die?
11. What role do I want my physician and other important persons to have in decisions about my medical care, especially if I am unable to communicate my wishes?
12. How do I feel about organ and tissue donation?
13. How do I want to live the last days of my life?

## QUESTIONS AND ANSWERS ABOUT MINNESOTA LAW

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury. The information that follows tells about health care directives and how to prepare them. It does not give every detail of the law.

If you want more information, contact your health care provider, your attorney, the Office of the Ombudsman for Older Minnesotans, at (800) 657-3591 or (651) 296-0382, or the University of Minnesota Extension Service, at (800) 876-8636 or (612) 624-2900; e-mail: [order@dc.extension.umn.edu](mailto:order@dc.extension.umn.edu).

### **What is a health care directive?**

A health care directive is a written document that informs others of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a health care directive.

### **Why have a health care directive?**

A health care directive is important if your attending physician determines you cannot communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your directive may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

### **Must I have a health care directive? What happens if I don't have one?**

You don't have to have a health care directive. But writing one helps to make sure your wishes are followed.

You will still receive medical treatment if you do not have a written directive. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a health care directive.

### **How do I make a health care directive?**

There are forms for health care directives. You can get them from your health care provider, attorney or the Minnesota Board on Aging at (800) 882-6262 or (651) 296-2770. You do not have to use a form, but your health care directive must meet the following *requirements* to be legal:

- Be in writing and dated;
- State your name;
- Be signed by you or someone you authorize to sign for you when you can understand and communicate your health care wishes;
- Have your signature verified by a notary public or two witnesses; and

- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make.

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider.

**I have prepared my directive in another state. Is it still good?**

Health care directives prepared in other states are legal if they meet the requirements of the other state’s laws or the Minnesota requirements. But requests for assisted suicide will not be followed.

**What can I put in a health care directive?**

You have many choices of what to put in your health care directive. For example, you may include:

- The person you trust as your agent to make health care decisions for you. You can name alternate agents in case the first agent is unavailable, or joint agents;
- Your goals, values and preferences about health care;
- The types of medical treatment you would want (or not want);
- How you want your agent or agents to decide;
- Where you want to receive care;
- Instructions about artificial nutrition and hydration;
- Mental health treatments that use electroshock therapy or neuroleptic medications;
- Instructions if you are pregnant;
- Donation of organs, tissue and eyes;
- Funeral arrangements; and
- Who you would like as your guardian or conservator if there is a court action.

You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your health care directive.

**Are there any limits to what I can put in my health care directive?**

There are some limits about what you can put in your health care directive. For instance:

- Your agent must be at least 18 years of age;
- Your agent cannot be your health care provider unless the health care provider is a family member or you give reasons for the naming of the agent in your directive;
- You cannot request health care treatment that is outside of reasonable medical practice; and
- You cannot request assisted suicide.

**How long does a health care directive last? Can I change it?**

Your health care directive lasts until you change or cancel it. As long as the health care directive requirements listed above, you may cancel your directive by any of the following:

- A written statement saying you want to cancel it;

- Destroying it;
- Telling at least two other people you want to cancel it; or
- Writing a new health care directive.

**What if my health care provider refuses to follow my health care directive?**

Your health care provider must follow your health care directive or any instructions from your agent as long as the health care follows reasonable medical practice. But you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agent to arrange to transfer you to another provider who will follow the agent's directions.

**What if I have already prepared a health care document? It is still good?**

Before August 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable health care powers of attorney and mental health declarations.

The law changed so people can use one form for all their health care instructions.

Forms created before August 1, 1998 are still legal if they followed the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

**What should I do with my health care directive after I have signed it?**

You should inform others of your health care directive and give people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a health care directive. You should give them a copy. It is a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.



## CHECKLIST FOR COMPLETING A HEALTH CARE DIRECTIVE

1. Clarify your values and beliefs about life, death and the use of medical technology. Discuss your questions and concerns with the important people in your life, including your physician, family members, attorney and clergy.
2. Select a health care agent who agrees with your values and beliefs and whom you trust to act accordingly.

This person:

- Must be a competent adult, at least 18 years of age;
- Must agree to be named;
- Cannot be an employee of your health care provider unless that person is related to you by blood, marriage, registered domestic partnership, or adoption; and
- Cannot be the person appointed by you to make the determination of your decision-making capacity.

You may also want to consider selecting an alternate agent for situations when the first agent refuses or is unable to act.

3. Further discuss your wishes with your agent and other persons important to you. Put your specific instructions in writing.
4. Complete the health care directive form included in this booklet. The form may be photocopied.
5. Sign and date the form in the presence of a notary public or two witnesses. Your health care agent or alternate health care agent may not act as a witness. One of the witnesses can be an employee of your health care provider, but not both.
6. Give a copy of your completed document to your physician and discuss your wishes with her or him. Send a copy to the medical records department of the hospital at which you would most likely receive medical care.
7. Give copies of the health care directive to your agent and other important persons, including family members, attorney and clergy. Make sure you keep a readily accessible copy for yourself and file it with your other important documents.
8. Periodically review the documents to make sure they are current statements of your wishes. If you make changes, write and date the changes and discuss them with your physician, family, and agent.

**ADDITIONAL PROVISIONS WHICH MAY BE INCLUDED IN YOUR  
HEALTH CARE DIRECTIVE**

1. The designation of one or more alternate health care agents to act if the named health care agent is not reasonable available to serve.
2. Directions to joint health care agents regarding the process or standards by which the health care agents are to reach a health care decision for you, and a statement whether joint health care agents may act independently of one another.
3. Limitations, if any, on the right of the health care agent or any alternate health care agents to receive, review, obtain copies of, and consent to the disclosure of your medical records.
4. Limitations, if any, on the nomination of the health care agent as your guardian or conservator.
5. A document of gift for the purpose of making and anatomical gift, or an amendment to, revocation of, or refusal to make an anatomical gift.
6. A declaration regarding intrusive mental health treatment or a statement that the health care agent is authorized to give consent for you.
7. A funeral directive.
8. Limitations, if any, to the effect of dissolution or annulment of marriage or termination of domestic partnership on the appointment of a health care agent.
9. Specific reasons why you want your health care provider or an employee of your health care provider to be eligible to act as your health care agent.
10. If you are a woman of child-bearing age, health care instructions regarding how you would like your pregnancy, if any, to affect health care decisions for you.
11. Health care instructions regarding artificially administered nutrition or hydration.
12. A health care directive may include a statement of the circumstances under which the directive becomes effective other than upon the judgment of your attending physician in the following situations:
  - a. If you, in good faith, generally select and depend upon spiritual means or prayer for the treatment or care of disease or remedial care and do not have an attending physician, then you may include a statement appointing an individual who may determine your decision-making capacity; and

- b. If you, in good faith, do not generally select a physician or a health care facility for your health care needs, then you may include a statement appointing an individual who may determine your decision-making capacity, provided that if the need to determine your capacity arises when you are receiving care under the direction of an attending physician in a health care facility, the determination must be made by an attending physician after consultation with the appointment individual.

If a person appointed under clause (a) or (b) is not reasonably available and you are receiving care under the direction of an attending physician in a health care facility, an attending physician shall determine your decision-making capacity.

- 13. A health care directive may authorize a health care agent to make health care decisions for you even though you retain decision-making capacity.

## WHEN DOES MY HEALTH CARE DIRECTIVE BECOME EFFECTIVE?

Your health care directive is effective for a health care decision when it meets these requirements:

1. A health care directive must be signed by you or in your name by some other individual acting in your presence and by your direction. A health care directive must contain the date of its execution and must be witnessed or acknowledged by one of the following methods:
    - A. Signed by at least two individuals age 18 or older, each of whom witnessed either the signing of the instrument by you or your acknowledgement of the signature; or
    - B. Acknowledged by you before a notary public who is not the agent.
- and
2. You, in the determination of your attending physician, lack decision-making capacity to make the health care decision; or if other conditions for effectiveness otherwise specified by you have been met.

A health care directive is not effective for a health care decision when you, in the determination of your attending physician, recover decision-making capacity; or if other conditions for effectiveness otherwise specified by you have been met.

## HEALTH CARE DIRECTIVE

*NOTE: The following is a suggested form of a health care directive and is not a required form.*

I, \_\_\_\_\_, 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**

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 to speak for myself, I trust and appoint \_\_\_\_\_  
\_\_\_\_\_ to make health care decisions for me. This person is called  
by 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 alternative health care agent:**

If my health care agent is not reasonably available, I trust and appoint \_\_\_\_\_  
\_\_\_\_\_ to be my health care agent instead.

Relationships of my alternate health care agent to me: \_\_\_\_\_

Telephone number of my alternate health care agent: \_\_\_\_\_

Address of my alternate health care agent: \_\_\_\_\_

**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 my 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

decision 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 related 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: \_\_\_\_\_

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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**.

Initial: \_\_\_\_\_ (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 health care agent's powers or limits of the powers, I can say it here: \_\_\_\_\_

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**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 choose 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).

**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My fears about my health care: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 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: \_\_\_\_\_

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

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

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

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In all circumstances, my doctors 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:

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

Who I would like to be my doctor: \_\_\_\_\_

Where I would like to live to receive health care: \_\_\_\_\_  
\_\_\_\_\_

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 III: 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 I: NOTARY PUBLIC**

In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (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 health care agent or alternate health care agent in this document.

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed, sworn to and acknowledged before me by \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_, (year) \_\_\_\_\_.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Notary

**OPTION II: TWO WITNESSES**

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

• **Witness One:**

- (i) In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (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 health care agent or an alternate health care agent in this document.
- (iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial here: \_\_\_\_\_

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

Signature of Witness One: \_\_\_\_\_

Address: \_\_\_\_\_

• **Witness Two:**

- (v) In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (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.
- (vi) I am at least 18 years of age.
- (vii) I am not named as a health care agent or an alternate health care agent in this document.
- (viii) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial here: \_\_\_\_\_

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

Signature of Witness Two: \_\_\_\_\_

Address: \_\_\_\_\_

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

w/ss/health care directive  
4/00 12/07

**LIFECARE MEDICAL CENTER  
HEALTH CARE DIRECTIVES  
Treatment Choices**

**Attachment**

**Definitions of treatment choices on reverse side of page.**

Treatment or Procedure	When I am considered to have little or no chance of mental or physical recovery.			When I am considered to have a chance of mental but not physical recovery.			When I am considered to have a chance of physical but not mental recovery.		
	Want	Do not want	Don't know	Want	Do not want	Don't know	Want	Do not want	Don't know
Advanced Cardiac Life Support									
Antibiotics									
Artificial Hydration*									
Artificial Nutrition*									
Blood Transfusions									
CPR - Cardiopulmonary Resuscitation									
Kidney Dialysis									
Pain Medication									
Respirator									
Surgery-Major									
Surgery - Minor									
Tests - Major									
Tests - Minor									

\_\_\_\_\_  
Name Date

\_\_\_\_\_  
Notary Date

# HEALTH CARE DIRECTIVES

## Treatment Choices - Definitions

*The following definitions are to assist you in making the treatment choices listed on the reverse side of this page.*

**Advanced Cardiac Life Support** - Emergency medical procedures such as tube into mouth and nose to assist in breathing, medications into the vein or heart and/or electrical stimulation of the heart muscle.

**Antibiotics** - Providing medications to fight infections.

**Artificial Hydration** - Providing fluids through a tube into the vein, nose or stomach (by state law, refusal of artificial hydration is not honored in some states).

**Artificial Nutrition** - Providing nutrition through a tube into the vein, nose or stomach (by state law, refusal of artificial nutrition is not honored in some states).

**Blood Transfusions** - Providing blood through a tube into the vein.

**Cardiopulmonary Resuscitation (CPR)** - Emergency medical procedures such as manual compression of the chest to stimulate the heart and/or providing air into the lungs.

**Kidney Dialysis** - Cleaning the blood by machine.

**Pain Medication** - Providing medication to maintain comfort even if it may lead to reduced consciousness and/or shorten life.

**Respirator** - Use of a mechanical device to assist breathing.

**Surgery - Major** - Procedure such as opening the abdomen or chest to correct a problem.

**Surgery - Minor** - Procedure such as removal of diseased tissue from the surface of the body.

**Tests - Major** - Procedure such as using a tube to look into a body cavity.

**Tests - Minor** - Procedure such as x-ray or blood tests.

