Health Care Directives

Make Your
Wishes Known

There may come a time when you are unable to decide or tell us what you want. You have the opportunity now to make some decisions ahead of time. You can tell us in writing about the kind of care you would want if you could not speak for yourself. You do this through an Health Care Directive.

LRH – 08084 Rev. 10/2019 /Mktg/AllForms

LAKE REGION HEALTHCARE
712 Cascade St S • Fergus Falls, MN 56537
(218) 736.8000

Dear Patient,

You are being provided with a do-it-yourself form for preparing a health care directive, also called an advance directive or living will. We encourage all of our adult patients to complete these as a way of making sure your wishes are carried out in the event of a health emergency.

When you have completed your Health Care Directive, your signature needs to either be notarized or witnessed by two individuals who are NOT named as your health care agents. The Lake Region Healthcare social workers would be glad to witness or notarize your signature for you. A staff person at Lake Region Healthcare or Lake Region Healthcare Clinic Services can help you locate one of us, usually within a short time period. It may be more convenient for you to have friends witness your signature or to see a notary at your local bank.

It is very important to bring your completed Health Care Directive to your Doctor's office to have it copied for your medical record.

If you need assistance in the completion of this form, we have facilitators at Lake Region Healthcare who can help you. Please call Chaplain Deb Forstner, Lake Region Healthcare's Advance Care Planning Coordinator at (218) 736-8077, or Laura Denbrook, Lake Region Healthcare Social Services Director at (218) 736-8003. They will do their best to answer your questions.

Please be assured that there are no charges for notary fees or copy costs. We want to make sure that people have the assistance they need to complete these important documents.

Thank you for choosing Lake Region Healthcare and Clinic Services.

HEALTH CARE DIRECTIVE

Introduction

I have created this Health Care Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent to speak for me if I cannot communicate my wishes or make my own health care decisions. My Health Care Agent, as named in this document, is able to make medical decisions for me when I cannot speak for myself, due to illness or injury, including the decision to refuse treatments that I do not want.

NOTE: This document will not apply to any intrusive mental health treatments, defined as electroconvulsive therapy or neuroleptic medications.

Any advance directive document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

My telephone numbers: (home) _____ (cell) _____

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

SECTION I: My Health Care Agent

My Health Care Agent must…

- Be an adult
- Not be a health care provider giving me direct care unless I am related to that person; specify circumstance, if applicable, here: _____
- Follow my health care instructions in this document and any other instructions I have given to him or her, and make decisions that are in my best interest.

I choose the following person/s to communicate my wishes and make health care decisions:

My Primary (Main) Health Care Agent is:

Name: _____ Relationship: _____

Telephone numbers: (H) _____ (C) _____ (W) _____

Full Address: _____

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:

Name: _____ Relationship: _____

Telephone numbers: (H) _____ (C) _____ (W) _____

Full Address: _____

_____

This is the directive of (name): _____ Date Completed: _____

Powers of My Health Care Agent:

My Health Care Agent automatically has all the following powers when I am unable to communicate for myself:

A. Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, taking out or not putting in tube feedings, and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.

B. Interpret any instruction in this document based on his or her understanding of my wishes, values and beliefs.

C. Review and release my medical records and personal files as needed for my health care, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Minnesota Health Records Act.

D. Arrange for my health care and treatment in Minnesota or any other state or location he or she thinks is appropriate.

E. Decide which health care providers and organizations provide my health care.

F. Make decisions regarding organ and tissue donation and autopsy according to my instructions in Part Two of this document.

Comments or limits on the above:

Additional Powers of My Health Care Agent:

My initials below indicate I also authorize my Health Care Agent to:

☐ Make decisions about the care of my body after death.

☐ Continue as my Health Care Agent even if our marriage or domestic partnership is legally ending or has been ended.

☐ Make health care decisions for me even if I am able to decide or speak for myself, if I so choose.

☐ In the event I am pregnant, decide whether to try to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences and/or instructions.

This is the directive of (name): _____ ***Date Completed:*** _____

SECTION II: My Health Care Instructions

My choices and preferences for my health care are as follows: I ask my Health Care Agent to communicate these choices, and my health care team to honor them, if I cannot communicate or make my own choices. ***I have initialed the box below for the option I prefer for each situation.***

NOTE: *You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or in your best interest if your wishes are unknown.*

1. **Cardiopulmonary Resuscitation (CPR)**

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization. I understand that CPR can save a life, but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases, impaired functioning, or both. I understand that recovery from CPR can be painful and difficult.

Therefore:

☐ I want CPR attempted if my heart or breathing stops**.**

or

☐ I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed, then my agent or I (if I am able) should discuss CPR with my health care team. My choices in this Health Care Directive titled **Treatment Preferences** related to an existing condition (if applicable) and **Additional Treatments to Prolong My Life** should be considered when making this decision.

Examples of when my health has changed include:

- I have an incurable illness or injury and am dying
- I have no reasonable chance to recover my ability to know who I am or who I am with (i.e. severe permanent brain injury)
- I have little chance of long-term survival and CPR would cause significant suffering.

or

☐ I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand if I choose this option I should see my health care provider about writing a *Do Not Resuscitate* (DNR) order.

Additional instructions about this treatment: _____

_____

This is the directive of (name): _____ ***Date Completed:*** _____

2. Treatment Preferences: My Current Health Condition (if applicable)

I have listed here treatment preferences for **my specific health condition(s)**. These statements describe my treatment choices. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as foods and fluids by mouth if I am able to swallow.

Initial here if additional documents are attached: ☐

3. Additional Treatments to Prolong My Life: Decisions for the Future

These decisions refer to treatment choices I would want in the future if my health has changed to the point where I cannot make decisions or speak for myself.

A. **A Ventilator/Respirator** is a breathing machine used when I cannot breathe on my own. I understand that I cannot talk or eat by mouth when on this machine.

Therefore:

☐ I want a Ventilator/Respirator used.

☐ I want a Ventilator/Respirator used for an acute crisis to help me breathe for a trial period*.

☐ I do not want a Ventilator/Respirator used.

Additional Instructions about this treatment: _____

_____

B. **Nutritional Support and Hydration** mean that when I cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support my existence indefinitely. I realize that this treatment may involve putting a tube into my stomach, through my nose, into my intestine or into my veins.

Therefore:

☐ I want nutritional support and hydration.

☐ I want nutritional support and hydration procedures used in an acute crisis for a trial period*.

☐ I do not want nutritional support and hydration procedures used.

Additional Instructions about this treatment: _____

_____

*Trial Period means that this treatment may be used to see if my condition improves. If it does not, I want it discontinued. Length of trial period will be dependent on discussions with health care team.

This is the directive of (name): _____ ***Date Completed:*** _____

C. **Dialysis** is when a machine would be used to clean my blood when my kidneys are not working well. I understand that I may die sooner if this procedure is needed and is not done.

Therefore:

☐ I want dialysis done for me.

☐ I want dialysis done in acute situations for a trial period*.

☐ I do not want dialysis.

Additional Instructions about this treatment: _____

_____

D. **Blood Transfusions / Blood Products** may be used during surgery or as treatment for some diseases.

Therefore:

☐ I want Blood Transfusions / Blood Products.

☐ I want Blood Transfusions / Blood Products used in an acute crisis for a trial period*.

☐ I do not want Blood Transfusions / Blood Products.

Additional Instructions about this treatment: _____

_____

E. **Antibiotics** are used to treat infections and can be viewed as prolonging life support.

Therefore:

☐ I want Antibiotics used.

☐ I want Antibiotics used in an acute crisis for a trial period*.

☐ I do not want Antibiotics used.

Additional Instructions about this treatment: _____

_____

F. **Pain Management.** I want to be kept comfortable and as free of pain as possible.

Therefore:

☐ I want my Doctor to prescribe enough medication to relieve my pain.

☐ Even if it means that I may not interact very well with people, or that my ability to think clearly might be diminished, I want Pain Management.

Additional Instructions about this treatment: _____

_____

*Trial Period means that this treatment may be used to see if my condition improves. If it does not, I want it discontinued. Length of trial period will be dependent on discussions with health care team.

This is the directive of (name): _____ ***Date Completed:*** _____

4. Organ Donation

☐ I want to donate my eyes, tissues and/or organs, if able. My Health Care Agent, according to Minnesota Law, may start and continue treatments or 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.

or

☐ My Health Care Agent can decide.

5. Autopsy

☐ My Health Care Agent may request an autopsy if the autopsy can help others understand the cause of my death or help with future health care decisions.

or

☐ I do not want an autopsy unless required by law.

6. Comments or Directions to My Health Care Team:

You may use this space to write any additional instructions or messages to your health Care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.

This is the directive of (name): _____ ***Date Completed:*** _____

SECTION III: My Hopes and Wishes (Optional)

I want my loved ones to know my following thoughts and feelings:

1. The things that make life most worth living to me are:

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

3. My thoughts and feelings about how and where I would like to die:

4. If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (rituals, prayers, music, etc.):

5. Religious/Spiritual affiliation: I am of the _____ faith, and am a am a member of _____ faith community in (city) _____.

6. Other wishes/instructions:

Initial here if additional documents are attached: ☐

This is the directive of (name): _____ ***Date Completed:*** _____

SECTION IV: Legal Authority

Under Minnesota law, your signature and date must be verified by either two witnesses, or a notary public. Your Witnesses or Notary Public cannot be named as your Health Care Agent or Alternate.

I have made this document willingly, I am thinking clearly, and this document expresses my wishes about my future health care decisions:

Signature:_____ **Date:**_____

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

_____ _____

Printed Name **Signature** *(of person asked to sign)*

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: _____. One witness cannot be a provider or an employee of the provider giving direct care on the date this document is signed.

Witness Number One: **Witness Number Two:**

Signature _____ *Signature* _____

Date:_____ Date:_____

Print Name Print Name

_____ _____

Address (optional) Address (optional)

_____ _____

_____ _____

Notary Public:

In the state of Minnesota, County of _____.

In my presence on _____(date), _____(name) acknowledged his or her signature on this document or acknowledged that he or she authorized the person signing this document to 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): _____

This is the directive of (name): _____ ***Date Completed:*** _____

NEXT STEPS

(Keep for your records)

Now that you have completed your Health Care Directive, you should also take the following steps:

- Tell the person you named as your primary and alternate Health Care Agent, if you haven't already done so. Make sure they feel able to do this important job for you in the future.
- Give your primary and alternate Health Care Agent a copy of your Health Care Directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your Health Care Agent is, and what your wishes are.
- Give a copy of your Health Care Directive to your doctor and other health care providers. Make sure your wishes are understood and will be followed.
- Keep a copy of your Health Care Directive where it can be easily found.
- Take a copy of your Health Care Directive any time you are admitted to a health care facility, and ask that it be placed in your medical record.
- **Review your health care wishes every time you have a physical exam or whenever any of the "Five D's" occur:**

  Decade – when you start each new decade of your life.

  Death – whenever you experience the death of a loved one.

  Divorce – when you experience a divorce or other major family change.

  Diagnosis – when you are diagnosed with a serious health condition.

  Decline – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

Copies of this document have been given to:

Primary (Main) Health Care Agent
Name: _____
Telephone: _____ Cell: _____

Alternate Health Care Agent
Name: _____
Telephone: _____ Cell: _____

Health Care Provider/Clinic
Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

If your wishes change, <u>fill out a new health care directive form</u>. Give copies of the new form to your agent, your family, your doctor, and everyone who has copies of your old health care directive forms.

This is the directive of (name): _____ ***Date Completed:*** _____