Winona Health

855 Mankato Avenue, Winona, MN 55987 • Phone: 507.454.3650

Healthcare Directive

Name: _____

Address: _____

City, State, Zip: _____ Date of Birth: _____

Part I - Appointing an Agent

If I am no longer able to make my own healthcare decisions, this document names the person I choose to make these choices for me. This person will make my healthcare decisions when I am determined to be incapable to make healthcare decisions as provided under state law.

Instructions for Completing This Part:

When selecting someone to be your healthcare agent, pick someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Make sure that you pick someone who will closely follow what you want and will be a good advocate for you. Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your agent(s).

Your healthcare agent should be at least 18 years or older and should not be one of your healthcare providers or an employee of your healthcare provider unless they are a close relative.

The person I choose as my Healthcare Agent is:

Name: _____ Relationship: _____

Day phone: _____ Evening phone: _____ Cell phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

If this healthcare agent is unable or unwilling to make these choices for me, or if my spouse is designated as my healthcare agent and our marriage is annulled or we are divorced or legally separated, then my next choice for a healthcare agent is:

Second choice (Alternate Agent):

Name: _____ Relationship: _____

Day phone: _____ Evening phone: _____ Cell phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

Third choice (Alternate Agent):

Name: _____ Relationship: _____

Day phone: _____ Evening phone: _____ Cell phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

Part II - General Authority of the Healthcare Agent

I want my healthcare agent to be able to do the following: (Please cross out anything you do not want your healthcare agent to do that is listed below. *(Put your initial* (eg. DJ) *on the line next to each statement if you agree, and draw a line through the statement if you do not agree.)*

- To make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, my healthcare agent can keep it going or have it stopped depending upon my stated instructions or my best interests.
- To interpret any instruction I have given in this form or given in other discussions according to my healthcare agent's understanding of my wishes and values.
- To review and release my medical records and personal files as needed for my medical care.
- To arrange for my medical care and treatment in Wisconsin, Minnesota and Iowa or any other state, as my healthcare agent thinks appropriate.
- To determine which health professionals and organizations provide my medical treatment.

Part III – Points of Discussion Regarding Directives, Desires, Special Provisions or Limitations

My healthcare agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my healthcare agent and/or provider providing my medical care. If there are conflicts among my known values and goals, I want my agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this Power of Attorney for Healthcare, or my healthcare agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own healthcare.

Instructions for Completing This Part:

If you have appointed an agent in part I, you are **not required** to provide any written instructions or make any selections in Part III. If you choose **not** to provide any instructions, your healthcare agent will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write **"no instructions"** across the page.

(Put your initial (eg. DJ) *on the line next to each statement if you agree, and draw a line through the statement if you do not agree.)*

_____ If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with myself, my family, friends, and environment, I want to stop or withhold **all** treatments that might be used to prolong my existence.

_____ My healthcare agent has authority to admit me to a nursing home or community-base residential facility for the purpose of long-term care. *(without this directive a court order would be required in Wisconsin)*

_____ If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable.

Cardiopulmonary Resuscitation (CPR):

If I do not want CPR attempted, my provider should be made aware of this choice. If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency responders from attempting CPR in an emergency. Other documents (POLST *Providers Orders for Life Sustaining Treatment*) are needed to control the actions of emergency responders. [1] Institute of Medicine (IOM) noted that survival of <6% when cardiac arrest occurs outside of the hospital and only 24% when cardiac arrest occurs inside the hospital. A few possible side effects from CPR are broken ribs; you may need to be in an intensive care unit and on a breathing machine; you may have brain damage. (Reference: [1] Institute of Medicine: *Strategies to Improve Cardiac Arrest Survival: A Time to Act.* Washington DC: The National Academies Press; 2015)

(Initial one of the following statements and draw a line through the statements that you do not want.)

_____I want CPR attempted unless I am dying of an incurable illness or injury. The process of resuscitation will cause significant suffering.

_____I always want CPR.

_____I never want CPR.

Intubation and Mechanical Ventilation

Intubation is an emergent procedure in which medical personnel insert a breathing tube through the mouth into the throat. This tube is connected to a mechanical ventilator (machine) which performs artificial breathing. Mechanical ventilation may only be needed as a short-term treatment, but in some conditions may be needed longer. It is often difficult to know whether mechanical ventilation will be temporary at the time intubation is necessary.

_____I want intubation performed as a life saving measure if I am not able to breathe well enough on my own. Choose one of the two listed below:

____If mechanical ventilation will be necessary long term, I want a tracheostomy performed to prolong my life.

____I do NOT want a tracheostomy. If mechanical ventilation will be necessary long term and I cannot breathe on my own despite medical treatments, allow natural death.

_____I never want intubation.

After My Death:

_____I want an autopsy if it will help determine the cause of my death or aid blood relative's health decisions.

_____I do not want an autopsy.

_____I wish to be an organ donor.

_____I wish to be cremated. (Additional pre-planning is necessary)

_____I wish for _____to make my funeral arrangements.

Other health care or personal care instructions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Part IV- Making the Document Legal in Minnesota, Iowa or Wisconsin:

Minnesota or Iowa residents may have this document signed and dated in the presence of two witnesses or a notary public.

Wisconsin residents must have this document signed and dated in the presence of two witnesses.

Statement of Witnesses
I know this person to be the individual identified in the document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not a healthcare agent appointed by the person signing this document.
- Not related to the person signing this document by blood, marriage or adoption.
- Not directly financially responsible for that person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a healthcare provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

I am thinking clearly; I agree with everything that is written in this document and I have signed this document willingly in the presence of a Notary Public or two witnesses.

_____ _____

My signature *Date*

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

_____

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

_____

Print the name of the person I asked to sign this document for me.

Witness number 1:

_____ _____

Signature *Date*

_____

Print name

_____

Address

_____

City, State, Zip

Witness number 2:

_____ _____

Signature *Date*

_____

Print name

_____

Address

_____

City, State, Zip

Notary Public Option (Minnesota and Iowa Residents) *(Notary Stamp)*

_____ _____

Notary Public *Date*

After Completing This Document

After you complete the document, make copies to be given out as follows:

- One copy for yourself.
- One copy for the healthcare agent and alternates appointed in the document.
- One copy to share and discuss with your provider.
- One copy for your record at the hospital where you would go in an emergency.
- Extra copies to share with others if you wish (loved ones, your clergy, and your attorney).

A photo or fax copy is as legally valid as an original.

Copies of this document are being, or have been given, to:

1. _____
2. _____
3. _____
4. _____
5. _____