

# Health Care Directive / Power of Attorney for Health Care

Name (First, Middle, Last)		Birth Date: (mm-dd-yyyy)
Street Address		City
State	Zip	Primary Phone

## Part 1 – Appointing Your Health Care Agent

If I am no longer able to make my own health care decisions, this Power of Attorney for Health Care names the person I choose to make these choices for me.

I do not wish to name a health care agent. Instead I have completed Part 3 of this document to guide my health care if I am no longer able to make my own health care decisions.

### **Instructions for completing Part 1:**

When appointing your health care agent, select someone who:

- is at least 18 years or older
- knows you well, who you trust and is willing to respect your views and values
- will be an advocate for you and will act in your best interest
- is able to make difficult decisions under stressful circumstances
- is **NOT** one of your health care providers or an employee of your health care provider unless they are a close relative

**The person I choose as my health care agent is:** (please print)

Name (First, Middle, Last)		Relationship	
Address	City/State	Zip	
Primary Phone	Work Phone		

If this health care agent is unable or does not want to make health care decisions for me or if my spouse is designated as my health care agent and our marriage is annulled or we are divorced or legally separated, then my next choice(s) for a health care agent is/are:

**1<sup>st</sup> Alternate Agent:** (please print)

Name (First, Middle, Last)		Relationship	
Street Address	City/State	Zip	
Primary Phone	Work Phone		

**2nd Alternate Agent:** (please print)

Name (First, Middle, Last)		Relationship	
Street Address	City/State	Zip	
Primary Phone	Work Phone		

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## Part 2 – General Authority of the Health Care Agent

### **Instructions for Completing Part 2:**

Cross out and **initial** anything you **do not** want your health care agent to do.

I want my health care agent to:

- make choices for me about my medical care or services including tests, medications and surgery. If treatment has already been started, my health care agent can keep it going or have it stopped depending on my stated (or written) instructions or in my best interests.
- interpret any instruction(s) I have given in this document or given in other discussions regarding my health care agent's understanding of my wishes and values.
- review and release my medical records and personal files as needed for my medical care.
- arrange for my medical care and treatment in Minnesota, Wisconsin, Iowa or any other state as my health care agent thinks appropriate.
- determine which health professionals and organizations may take care of me.

### **Instructions for completing this section:**

Place your **initials** in the box for "Yes", "No" or "Does Not Apply"

[Wisconsin statute requires that you make a clear choice. This means if you **do not** indicate a choice in Wisconsin, a court order is required to make the decision, not your health care agent.]

#### **Agent Authority for the purpose of long-term care:**

**YES**, my health care agent has the authority to make a decision about admitting me to a nursing home or community-based residential facility (for example: assisted living) for a long-term stay.

**NO**, my health care agent does not have the authority to admit me to a nursing home or a community-based residential facility for a long-term stay.

#### **Agent Authority to order the withholding or withdrawal of feeding tube and intravenous (IV) hydration:**

**YES**, my health care agent has the authority to have a feeding tube or IV hydration started, stopped, continued, withheld or withdrawn from me subject to any limits I have set forth in this document.

**NO**, my health care agent does not have the authority to have a feeding tube or IV hydration withheld or withdrawn from me.

#### **Agent Authority to make decisions if I am pregnant:**

**YES**, my health care agent has the authority to make decisions for me if I am pregnant.

**NO**, my health care agent does not have the authority to make decisions for me if I am pregnant.

Not Applicable to me.

# Health Care Directive / Power of Attorney for Health Care

## Part 3 – Statement of Directives, Desires, Special Provisions or Limitations

My health care agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations I list here. The following are some specific instructions for my health care agent and/or medical provider. 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 Health Care/Health Care Directive, or my health care agent cannot be contacted, I want the instructions listed here to be followed based on my common law and constitutional right to direct my own health care.

### **Instructions for Completing Part 3:** (initial all that apply)

You are not required to provide any written instructions or make any selections in Part 3. If you choose not to provide any instruction, your health care agent will make decisions based on your oral instructions and discussions or what is considered to be in your best interest. *If you **do not** write specific wishes, your medical team will provide the best standard of care possible.*

### **Pain and Symptom Control:**

I want medical treatments and nursing care that will make me as comfortable and free of pain as possible.

I want my pain controlled even if there is a negative outcome such as my ability to think clearly or it may shorten my life.

### **Stopping Attempts of Life-Prolonging Treatments:**

If I reach a point where my medical providers are reasonably certain that I will not regain my ability to interact meaningfully with family, friends and the world around me (I don't know who I am, who I am with, or where I am) this is my choice:

I want to stop or withhold treatments that may prolong my life. These treatments include, but are not limited to: feeding tubes, blood products, IV hydration, CPR, respirator/ventilator, antibiotics.

**OR**

I want to receive **all** treatments that may keep me alive unless my provider determines that the treatments would harm me more than help me.

### **Cardiopulmonary Resuscitation (CPR):**

CPR is a part of basic life support which includes chest compressions and shocks to restart the heart. Based on my current health, this is my choice if my heart or breathing stops:

I want CPR attempted **unless** my provider determines:  
-I have a medical condition with no reasonable chance of survival with CPR.  
-CPR would harm me more than help me.

**OR**

I **do not** want CPR – let me die a natural death.

### **Intubation and Mechanical Ventilation:**

I want intubation performed as a life-saving measure if I am unable to breathe well on my own. A breathing tube is used to connect to a mechanical ventilator which performs artificial breathing. This may necessitate a need for a tracheostomy.

Allow a natural death if it is determined mechanical ventilation will be necessary long term because I cannot breathe on my own despite medical treatments.

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## Part 3 – Statement of Directives, Desires, Special Provisions or Limitations – continued

### Upon My Death:

**Autopsy** (If required by law there is no charge; if not required by law, it is at the expense of your estate.):

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

OR

I **do not** want an autopsy performed on my body.

### Donating My Organs and Tissues (examples: kidney, liver, heart, lung, eye, skin, bone):

I consent to donate my organs or tissues if I am a candidate. If possible, I only want to donate these specific organs or tissues: \_\_\_\_\_

OR

I **do not** want to donate any organs or tissues.

### Donating My Body to scientific research:

I have made arrangements with \_\_\_\_\_ to donate my body for scientific research.  
I understand I cannot be an organ or tissue donor.

### Other Information and Requests:

My funeral home designation, cremation or burial plans are as follows:

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I am a member of this (congregation, synagogue or worship group) and would like them notified of my wishes (rituals, customs, sacraments) if I am nearing death:

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Other instructions for personal care (example: haircuts, dentures, glasses) or for comfort measures (example: music, pictures, blanket/pillows) or for medical care (example: blood transfusion, dialysis, etc.)

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# Health Care Directive / Power of Attorney for Health Care

## Part 4 – Making the Document Legal

**Minnesota or Iowa** residents may have this document signed and dated in the presence of two witnesses **OR** a Notary Public. MN Statutes meet or exceed Iowa requirements.

*MN Statute Definitions:* Health care provider means a person, health care facility or organization.

*MN Statute 145C.03(3)(b) paraphrased:* At least one witness to the execution of the health care directive must not be a health care provider or his or her employee providing direct care to the principal. A person notarizing a health care directive may be an employee of a health care provider providing direct care to the principal.

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

*WI Statutes 155.10(2)(d) paraphrased:* Neither witness can be an employee of the health care facility other than a chaplain or a social worker.

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 two witnesses or a Notary Public.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date (mm-dd-yyyy)

I agree with everything in this document but I cannot sign my name. The person named below signed this document in my presence for me.

\_\_\_\_\_  
Patient Representative Signature

\_\_\_\_\_  
Print Name (First, Middle, Last)

\_\_\_\_\_  
Date (mm-dd-yyyy)

### Statement of Witnesses:

I know this person to be the individual identified in the document. I believe this person to be of sound mind and at least 18 years of age. I personally witnessed the signing of this document, and I believe that it was done so voluntarily.

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

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

### Witness 1:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name (First, Middle, Last)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

### Witness 2:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name (First, Middle, Last)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

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## Notarization:

**Minnesota and Iowa Residents:** This document may be notarized in their state, instead of having two witnesses.

**Wisconsin:** Notarization of this document is not legal for residents of Wisconsin.

## Notary Public:

In the state of: Minnesota/Iowa (circle one)

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 or alternate health care agent in this document.

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

\_\_\_\_\_  
Title of Office (and rank for Military Personnel)

\_\_\_\_\_  
My Commission Expires (date)

**Notary Stamp**  
(required)

## After Completing This Document:

A photo or fax copy is as legally valid as the original. Provide copies to your hospital, medical providers and health care agent. You may want copies to be given to close family and friends. Copies of this document have been given to the following health care organizations and people:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |