



# **An Advance Health Care Directive**

**Mayo Clinic Number** \_\_\_\_\_ **Name** \_\_\_\_\_



# An Advance Health Care Directive

Note: This form meets the legal requirements for an advance health care directive under Minnesota law. Other forms also may meet the Minnesota requirements. If you live in another state, please be sure this form meets your state's requirements before you fill it out.

Use the Mayo Clinic publication *Advance Health Care Planning: Making Your Wishes Known* (MC2107-05) to guide you through the steps of filling out this form.

## Purpose of this form

This form has three parts:

- **Part I** lets you appoint a health care agent to make medical decisions for you if you are not able to decide or speak for yourself. You can also name an alternate agent if you wish.
- **Part II** lets you state your health care wishes to guide others who make medical decisions for you.
- **Part III** has a place for you to sign the form.

## How to complete this form

- **Fill out Part I or Part II or both.** There are no right or wrong answers, only your answers.
  - **If you fill out Part I**, you do not have to fill out Part II. However, what you say in Part II can be very helpful to your agent and your health care providers.
  - **If you do not fill out Part I**, you must fill out some or all of Part II.
- **Sign and date this form** in front of either two witnesses or a notary public.

## What to do after you complete this form

- **Keep this form in a safe place** where your health care agent and family members can find it easily. Do not keep it in a safe-deposit box.
- **Let others know about this document.** Give copies of your signed form to your:
  - Health care agent and alternate agent if you appoint one.
  - Primary health care provider.
  - Any hospital, home care agency, hospice, or nursing facility where you receive care. Ask to have this form added to your medical record wherever you get care.
  - You also may wish to give copies to other people such as your family members, close friends, attorney or spiritual advisor.
- **Review your advance health care directive every few years** and talk about it with those close to you. Your plan is a work in progress.



# An Advance Health Care Directive

Form content retained in medical record.  
Route to HIMS Scanning.

**TO BE  
SCANNED**

(complete fields or place patient label here)

Patient Name (First Middle Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

## Advance Health Care Directive

I, \_\_\_\_\_, am using this form to do one or both of the following:

- Appoint a health care agent to make health care decisions for me if I cannot decide or speak for myself.
- State my wishes about the kind of health care I want.

### Part I: My health care agent

#### Appointment of health care agent

**When I am not able to decide or speak for myself, I appoint the following person as my health care agent or alternate agent to make health care decisions for me.**

- I want my agent to use what I say in this document and any other instructions or wishes I have made known to my agent as a general guide when making decisions about my care.
- If I have not given health care instructions, I want my agent to act in my best interest.

#### My primary health care agent

Name: \_\_\_\_\_ Relationship to me (if any): \_\_\_\_\_

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

Phone numbers: \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile)

#### My alternate health care agent if I have chosen one

If I cancel my primary agent's authority, or if my primary agent is not willing, able or reasonably available, I appoint as my alternate health care agent:

Name: \_\_\_\_\_ Relationship to me (if any): \_\_\_\_\_

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

Phone numbers: \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile)



# An Advance Health Care Directive (continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

## Powers of my health care agent

My agent automatically has the powers listed below in items A through D. If I **do not** want my agent to have any power listed below, I must cross out that item.

Whenever I am not able to decide or speak for myself, my health care agent can:

- A. Make any health care decision for me. This includes the power to agree to, refuse, change or stop any care, treatment, service or procedure. This also includes the power to decide whether to stop health care that is keeping me alive or to not start health care that might keep me alive.
- B. Choose my health care providers.
- C. Choose where I live and get health care and support. This includes the authority to admit me to a nursing home or community-based residential facility.
- D. Review my medical records and give them to other people as needed for my medical care.

If I **want** my agent to have any of the powers listed below, I must put my initials on the line in front of the power. My agent also can:

- \_\_\_\_\_ 1. Decide what happens with my body when I die. This includes my wishes about burial or cremation, autopsy, and donation of my organs, tissues or body.
- \_\_\_\_\_ 2. Decide about mental health treatment including electroconvulsive therapy and antipsychotic medicines including neuroleptic medicines.
- \_\_\_\_\_ 3. If I am pregnant, decide what treatment I should have, including no treatment at all.
- \_\_\_\_\_ 4. Make health care decisions for me even if I am able to decide or speak for myself.
- \_\_\_\_\_ 5. Continue to act as my agent even if we are in the process of or have completed a dissolution, annulment or termination of our marriage or domestic partnership.

Other instructions I have about the powers I give to my health care agent or about any limits I place on the powers of my agent: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# An Advance Health Care Directive (continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

## Part II: My health care wishes

**Instructions:** If you did not appoint a health care agent in Part I, you must fill out some or all of Part II. If you did appoint a health care agent, you should still think about filling out Part II. What you say in Part II can be very helpful to your agent and health care providers.

**When I am not able to decide or speak for myself, I have the following preferences about my health care.**

I want my health care agent, health care providers and those close to me to know these things about me.

I want them to use this information to help them decide about my health care.

### What is most important to me

These things give me joy and purpose. They make my life worth living:

---

---

---

---

---

---

---

---

---

---

I have these concerns or fears about medical treatment:

---

---

---

---

---

---

---

---

---

---

# An Advance Health Care Directive

(continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

**Instructions:** Agree or disagree with the following statements. If I have a serious injury or illness that cannot be cured, and will be in the following situation(s) for the rest of my life:

	<b>Agree</b>	<b>Disagree</b>
1. I feel my life would no longer be worth living if I cannot think clearly or make my own decisions.	<input type="checkbox"/>	<input type="checkbox"/>
2. I feel my life would no longer be worth living if I cannot understand what others say or interact with others in a meaningful way.	<input type="checkbox"/>	<input type="checkbox"/>
3. I feel my life would no longer be worth living if I cannot feed, bathe, or take care of myself.	<input type="checkbox"/>	<input type="checkbox"/>
4. I feel my life would no longer be worth living if I cannot walk.	<input type="checkbox"/>	<input type="checkbox"/>
5. I feel my life would no longer be worth living if I cannot control my bladder or bowels.	<input type="checkbox"/>	<input type="checkbox"/>
6. I feel my life would no longer be worth living if I have severe pain almost all the time and need medicine that makes me think less clearly, and there is little chance that this will improve.	<input type="checkbox"/>	<input type="checkbox"/>
7. I feel my life would no longer be worth living if I have other severe symptoms almost all the time for example, nausea or trouble breathing, and there is little chance that this will improve.	<input type="checkbox"/>	<input type="checkbox"/>
8. I feel my life would no longer be worth living if I must use machines to stay alive and there is little chance that this will improve.	<input type="checkbox"/>	<input type="checkbox"/>
9. I feel my life would no longer be worth living if I need to live in a nursing home or assisted care facility.	<input type="checkbox"/>	<input type="checkbox"/>

10. I feel my life would no longer be worth living if I can't do these activities:

---

---

---

---

---

# An Advance Health Care Directive (continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

## My treatment preferences

If possible, I would like my primary health care provider to be: \_\_\_\_\_

Whenever possible, I would like to receive health care at: \_\_\_\_\_

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include a breathing machine, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, kidney dialysis, antibiotics and blood transfusions. Most medical treatments can be tried for a period of time and then stopped if they do not help.

## When I am not able to decide or speak for myself, I have the following preferences about my health care.

**Instructions:** Put your initials next to the choice you prefer for each situation below. Cross out the choices you do not want.

### Treatments to prolong my life

If I reach a point where it is reasonably certain that I will not recover the ability to think clearly and interact with others in a meaningful way:

\_\_\_\_\_ I want all possible efforts to prolong life made on my behalf, even if it means I may remain on life-sustaining equipment such as a breathing machine or kidney dialysis for the rest of my life.

**OR**

\_\_\_\_\_ I want my health care providers to try treatments to prolong my life for a period of time. However, if I cannot return to an acceptable quality of life, I would like these treatments to stop.

**OR**

\_\_\_\_\_ I want to stop or withhold all treatments to prolong my life, and keep me comfortable as I near the end of my life.



(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

# An Advance Health Care Directive (continued)

## Cardiopulmonary resuscitation (CPR)\*

### If my heart or breathing stops:

\_\_\_\_\_ I want CPR in all cases.

### OR

\_\_\_\_\_ I want CPR unless my health care providers determine that I have any of the following:

- An injury or illness that cannot be cured and I am dying.
- No reasonable chance of surviving if my heart or breathing stops.
- Little chance of surviving long term if my heart or breathing stops and it would be hard and painful for me to recover from CPR.

### OR

\_\_\_\_\_ I do not want CPR but instead want to die a natural death.

\*For more information about CPR, see the Mayo Clinic publication Advance Health Care Planning: Making Your Wishes Known (MC2107-05).

## Pain relief

I understand that my health care providers will try to keep me comfortable in all situations. They will try to lessen my pain. If I am in pain, I would also like these things for comfort and support:

---



---



---

If pain relief could shorten my life or change how alert I am, I would want:

---



---



---

# An Advance Health Care Directive (continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

## My wishes and thoughts about death

### How and where I would like to die

If I am nearing my death, I would like these things for support and comfort:

---

---

---

If I am dying, I would like to be (check one):  at home  in a hospital  not sure

### Religion or spirituality

I am of the \_\_\_\_\_ faith or think of myself as \_\_\_\_\_.

I am a member of the \_\_\_\_\_ church, synagogue, or faith community. Please try to let them know of my death.

I want my health care providers to know these things about my religion or spirituality:

---

---

---

---

### My other wishes:

---

---

---

---

# An Advance Health Care Directive (continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

## After I die

### Donating my organs, tissues or body

Check the box next to your choice or leave the boxes blank if you prefer.

I **do** want to donate my eyes, organs, and tissues, if possible. Write initials in the blank after completing each step.

\_\_\_\_\_ I have indicated this choice on my driver's license or state-issued identification card.

\_\_\_\_\_ I am registered on my state's online donor registry.

I **do not** want to donate my eyes, organs and tissues.

I want to donate only my \_\_\_\_\_.

I **do** want to donate my body for scientific research. I have made arrangements for this with the following institution: \_\_\_\_\_

I understand that selecting the above box does not enroll me in a program. I must complete all necessary documentation required by that institution to fully consent and register for their body donation program.

I **do not** want to donate my body for scientific research.

### My other requests

Use this space to write other requests you may have such as autopsy, cremation, or burial:

---

---

---

\_\_\_\_\_ I must put my initials here if I have attached additional instructions about my health care.

# An Advance Health Care Directive (continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

## Part III: Making the form legal

You may choose to sign and date this form in front of two witnesses or in front of a notary public.

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

My Signature ▶	Sign Date (mm-dd-yyyy)
My Address (Street, City, State, ZIP Code)	

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

Printed name of person I asked to sign this document for me (First Middle Last)	
Signature ▶	Sign Date (mm-dd-yyyy)

### Option 1:

**Use this if you sign in front of two witnesses.**

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

**Note:** At Mayo Clinic, employees cannot sign as a witness. If you do not have two other witnesses, please use Option 2. Mayo Clinic can provide notary public service.

### Witness One:

1. In my presence on \_\_\_\_\_, \_\_\_\_\_  
(date) (name)  
acknowledged their signature on this document or acknowledged that they authorized the person signing this document to sign on their behalf.
2. I am at least 18 years old.
3. I am not named as a health care agent or an alternate health care agent in this document.
4. If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in item 1, I must put my initials in this box:

I certify that the information in items 1, 2, 3 and 4 is true and correct.

Witness One Signature ▶
Address (Street, City, State, ZIP Code)

# An Advance Health Care Directive (continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

## Witness Two:

1. In my presence on \_\_\_\_\_, \_\_\_\_\_  
(date) (name)  
acknowledged their signature on this document or acknowledged that they authorized the person signing this document to sign on their behalf.
2. I am at least 18 years old.
3. I am not named as a health care agent or an alternate health care agent in this document.
4. If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in item 1, I must put my initials in this box:

I certify that the information in items 1, 2, 3 and 4 is true and correct.

Witness Two Signature ▶
Address (Street, City, State, ZIP Code)

## Option 2:

### Use this if you sign in front of a notary public.

In my presence on \_\_\_\_\_, \_\_\_\_\_  
(date) (name)  
acknowledged their signature on this document or acknowledged that they authorized the person signing this document to sign on their behalf. I am not named as a health care agent or alternate health care agent in this document.

Notary Signature ▶
-----------------------

Notary Stamp:

# Questions and Answers About Minnesota Law on Health Care Directives

## 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.

## 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 can't 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 don't 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 don't 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.
- 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.

Information about how to obtain forms for preparation of your health care directive can be found in the Resource Section of this document.

## **I 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 alternative 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, tissues and eyes.
- Funeral arrangements.
- 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.
- 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 changes meet 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.
- Writing a new health care directive.

## **What if My Health Care Provider Refuses To Follow My Health Care Directive?**

Your health care provider generally will 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 agency to arrange to transfer you to another provider who will follow the agent's directions.

## **What if I've Already Prepared a Health Care Document? Is It 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's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.

## **What if I Believe a Health Care Provider Has Not Followed Health Care Directive Requirements?**

Complaints of this type can be filed with the Office of Health Facility Complaints at 651-201-4200 (Metro Area) or toll-free at 1-800-369-7994.



## **What if I Believe a Health Plan Has Not Followed Health Care Directive Requirements?**

Complaints of this type can be filed with the Minnesota Health Information Clearinghouse at 651-201-5178 or toll-free at 1-800-657-3793.

## **How To Obtain Additional Information**

If you want more information about health care directives, please contact your health care provider, your attorney, or: Minnesota Board on Aging's Senior LinkAge Line 1-800-333-2433.

A suggested health care directive form is available on the internet at:

[mn.gov/board-on-aging/connect-to-services/legal/advanced-care-planning/advance-directives](http://mn.gov/board-on-aging/connect-to-services/legal/advanced-care-planning/advance-directives)

Text was prepared by the Minnesota Department of Health

Reprinted 2013 by Mayo Clinic with permission from MN Department of Health



**Mayo Clinic Number** \_\_\_\_\_ **Name** \_\_\_\_\_

