

Minnesota Health Care Directive

This document is to be used if I cannot make decisions or communicate for myself. I will provide a copy of this document to my health care team and my health care agent(s).

This document replaces any other health care directives I completed in the past.

The glossary at the end of this document provides definitions that help me, my health care agent(s), and my health care providers to understand the instructions I provide in this document.

Table of Contents

My Information.....	Page 2
My Health Care Agent(s), Decisions About My Body After I Die.....	Page 2-3
Emergency Treatment.....	Page 4
If I am in a Permanent Vegetative State	Page 5
If I am Chronically or Terminally Ill.....	Page 6-7
Hospice	Page 8
Pain Management.....	Page 8
After I Die.....	Page 8-9
Additional Documents Included with this Health Care Directive.....	Page 9
Making This Document Legal.....	Page 10
Glossary of Terms.....	Page 11-12



**GILDA'S CLUB
MINNESOTA**
An Affiliate of the
CANCER SUPPORT COMMUNITY

Print Name: _____ Date: _____ Page 1 of 12

My Information

Full name: _____ Date of Birth: _____

Address: _____

Cell Phone Number: _____ Home Phone Number: _____

My Health Care Agent(s)

My Health Care Agent

Name: _____ Relationship to me: _____

Address: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

☐ This person has permission to make decisions about what happens to my body after I die.

(Optional) My First Alternative Health Care Agent

Name: _____ Relationship to me: _____

Address: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

☐ This person has permission to make decisions about what happens to my body after I die.

(Optional) My Second Alternative Health Care Agent

Name: _____ Relationship to me: _____

Address: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

☐ This person has permission to make decisions about what happens to my body after I die.

Print Name: _____ Date: _____ Page 2 of 12

Decisions About My Body After I Die

If I did not select anyone above to make decisions about what happens to my body after I die, this person has permission to make decisions about what happens to my body after death:

Name: _____ Relationship to me: _____

Address: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

To the best of their ability, my health care agent must follow my instructions in this document and any other instructions I have given to them.

[The remainder of this page is intentionally left blank]

Print Name: _____ Date: _____ Page 3 of 12

Emergency Treatment

If I have no pulse and am not breathing

- ☐ ATTEMPT Resuscitation/CPR. I understand this option includes accepting Full Treatment from health care providers including but not limited to: intubation, advanced airway interventions, mechanical ventilation, medications, and transfer to hospital and/or intensive care unit.
- ☐ DO NOT ATTEMPT Resuscitation/CPR- Allow natural death. I understand if I choose this option, I should contact my primary health care provider about completing a Provider Orders for Life-Sustaining Treatment (POLST).

If I have a pulse and/or am breathing, I want the following treatment: *(Select only one treatment option- Full Treatment, Selective Treatment, or Comfort-Focused Treatment)*

- ☐ FULL TREATMENT: I want to receive all viable treatment interventions to save, sustain, or prolong my life (such as, but not limited to, intubation, advanced airway interventions, mechanical ventilation, transfer to hospital and/or intensive care unit, and any other treatments deemed necessary by my treatment team).
- ☐ SELECTIVE TREATMENT *(check all that apply)*: I DO NOT want intubation, advanced airway interventions, and mechanical ventilation. I DO want to receive the following treatments:
- ☐ Antibiotics
 - ☐ IV Fluids
 - ☐ Less invasive airway support (CPAP, BIPAP)
 - ☐ Artificial nutrition (e.g. feeding tube, TPN)
 - ☐ Dialysis
 - ☐ Blood product transfusion
 - ☐ Other(s): _____
- ☐ COMFORT-FOCUSED TREATMENT- Allow natural death: Relieve pain and suffering through the use of any medication by any route, positioning, wound care, and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatments. Transfer to hospital if comfort needs cannot be met in current location.

Additional Notes: _____

Print Name: _____ Date: _____ Page 4 of 12

If I am in a Permanent Vegetative State

If I am in a permanent vegetative state, I want the following treatment: *(Select only one treatment option- Full Treatment, Selective Treatment, or Comfort-Focused Treatment)*

- ☐ FULL TREATMENT: I want to receive all viable treatment interventions to save, sustain, or prolong my life (such as, but not limited to, intubation, advanced airway interventions, mechanical ventilation, transfer to hospital and/or intensive care unit, and all the Selective Treatment options listed below).
- ☐ SELECTIVE TREATMENT *(check all that apply)*: I DO NOT want intubation, advanced airway interventions, and mechanical ventilation. I DO want to receive the following treatments:
- ☐ Antibiotics
 - ☐ IV Fluids
 - ☐ Less invasive airway support (CPAP, BIPAP)
 - ☐ Artificial nutrition (e.g. feeding tube, TPN)
 - ☐ Dialysis
 - ☐ Blood product transfusion
 - ☐ Other(s): _____
- ☐ COMFORT-FOCUSED TREATMENT- Allow natural death: Relieve pain and suffering through the use of any medication by any route, positioning, wound care, and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatments. Transfer to an appropriate care facility if comfort needs cannot be met in current location.

Additional Notes: _____

[The remainder of this page is intentionally left blank]

Print Name: _____ Date: _____ Page 5 of 12

If I am Chronically or Terminally Ill

If I am chronically or terminally ill, my treatment preferences depend on whether I still CAN or CAN NO LONGER do certain things.

If I CAN still do these things (e.g. hold a meaningful conversation with others, toilet myself, feed myself, etc.) _____

_____, then I want the following treatment: *(Select only one treatment option- Full Treatment, Selective Treatment, or Comfort-Focused Treatment)*

- ☐ **FULL TREATMENT:** I want to receive all viable treatment interventions to save, sustain, or prolong my life (such as, but not limited to, intubation, advanced airway interventions, mechanical ventilation, transfer to hospital and/or intensive care unit, and all the Selective Treatment options listed below).
- ☐ **SELECTIVE TREATMENT** *(check all that apply):* I DO NOT want intubation, advanced airway interventions, and mechanical ventilation. I DO want to receive the following treatments:
- ☐ Antibiotics
 - ☐ IV Fluids
 - ☐ Less invasive airway support (CPAP, BIPAP)
 - ☐ Artificial nutrition (e.g. feeding tube, TPN)
 - ☐ Dialysis
 - ☐ Blood product transfusion
 - ☐ Other(s): _____
- ☐ **COMFORT-FOCUSED TREATMENT-** Allow natural death: Relieve pain and suffering through the use of any medication by any route, positioning, wound care, and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatments.

Additional Notes: _____

Print Name: _____ Date: _____ Page 6 of 12

If I am Chronically or Terminally Ill (continued)

If I CAN NO LONGER do these things (e.g. hold a meaningful conversation with others, toilet myself, feed myself, etc.)_____

_____, then I want the following treatment: *(Select only one treatment option- Full Treatment, Selective Treatment, or Comfort-Focused Treatment)*

- ☐ FULL TREATMENT: I want to receive all viable treatment interventions to save, sustain, or prolong my life (such as, but not limited to, intubation, advanced airway interventions, mechanical ventilation, transfer to hospital and/or intensive care unit, and all the Selective Treatment options listed below).
- ☐ SELECTIVE TREATMENT *(check all that apply)*: I DO NOT want intubation, advanced airway interventions, and mechanical ventilation. I DO want to receive the following treatments:
- ☐ Antibiotics
 - ☐ IV Fluids
 - ☐ Less invasive airway support (CPAP, BIPAP)
 - ☐ Artificial nutrition (e.g. feeding tube, TPN)
 - ☐ Dialysis
 - ☐ Blood product transfusion
 - ☐ Other(s): _____
- ☐ COMFORT-FOCUSED TREATMENT- Allow natural death: Relieve pain and suffering through the use of any medication by any route, positioning, wound care, and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatments.

Additional Notes:_____

[The remainder of this page is intentionally left blank]

Print Name: _____ Date: _____ Page 7 of 12

Hospice

☐ I am interested in exploring hospice options if I am facing a prognosis of six months or less.

Additional Notes: _____

Pain Management

I want my pain and symptoms to be managed by these options:

☐ Any pain management options that are available to me in consultation with my provider

☐ Try non-opioid interventions first, and if unsuccessful, then proceed with opioids

☐ Other(s): _____

Additional Notes: _____

After I Die

Organ Donation

☐ I want to donate parts of my body after I die.

☐ I have made special arrangements for organ donation. Please see attached documents for information.

☐ I DO NOT want to donate parts of my body after I die.

Burial

☐ Traditional burial

☐ Traditional cremation

☐ Water cremation (also known as alkaline hydrolysis)

☐ Green burial (also known as earth burial)

☐ Natural organic reduction (also known as human composting)

☐ Other: _____

Additional Notes: _____

Print Name: _____ Date: _____ Page 8 of 12

Funeral Home Information

Name: _____

Address: _____

Phone Number: _____

Additional Documents Included with this Health Care Directive

The following documents are additional instructions and are included with and incorporated into this health care directive. These documents are attached at the end of this health care directive.

- ☒ Glossary of Terms
- ☐ My Health Care Goals
- ☐ Dementia Addendum
- ☐ Psychiatric Directive
- ☐ Organ Donation Information
- ☐ Other(s): _____

[The remainder of this page is intentionally left blank]

Print Name: _____ Date: _____ Page 9 of 12

Making This Document Legal

STOP! DO NOT SIGN this document until you are in front of a notary public or 2 witnesses.

1. **My Signature:** Sign _____ Date _____
2. **Verification:** Sign this document in front of a Notary Public OR 2 Witnesses

Notary Public

STATE OF MINNESOTA

County of _____ (county where signature is made)

In my presence on _____ (date), _____
(name of person signing this healthcare directive) acknowledged their signature on this document. I am not named as a health care agent or alternative health care agent in this document.

Signature of Notary: _____ Notary seal below:

My commission expires: _____

OR

Statement of Witnesses

I am at least 18 years old. I am not appointed as a health care agent or alternative health care agent in this document. Only one witness can be a health care provider or employee of a health care provider. If I am a health care provider or employee of a health care provider giving direct care to the person completing this document, I will place my initials here: _____

Witness 1:

Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: _____

Witness 2:

Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: _____

Print Name: _____ Date: _____ Page 10 of 12

Glossary of Terms

BiPAP / BPap (bilevel positive airway pressure): A type of noninvasive ventilation that delivers variably pressurized air through a mask to support breathing for people who are not getting enough oxygen or who cannot eliminate carbon dioxide on their own.

Brain Death: The complete and irreversible loss of all brain function, including the brain stem. A person who is brain dead is medically and legally dead and has no chance of survival. Brain death is different from being in a permanent vegetative state (see permanent vegetative state).

Chronic Illness: A condition that lasts several months or longer and requires ongoing medical attention and/or limits activities of daily living.

CPAP (continuous positive airway pressure): A type of noninvasive ventilation that delivers constant, pressurized air through a mask or nose cannula to help keep airways open for people who are able to breathe on their own.

CPR (Cardiopulmonary Resuscitation): An emergency procedure performed when a person's breathing or heartbeat has stopped, involving chest compressions and artificial breathing, used to maintain blood circulation and oxygen flow to the internal organs. CPR is often the first step in the resuscitation process used to try to restart the heart and lungs if they have stopped working. Resuscitation can involve: CPR, intubation, shocks (such as defibrillation), and medicines.

Emergency Treatment: Immediate medical care intended to stabilize an illness or injury that poses a threat to life or permanent health.

Hospice Care: A philosophy of care sought by people seeking comfort, dignity, and quality of life, rather than curative treatment for a terminal illness with a life expectancy of six months or less. It is a comprehensive approach encompassing pain and symptom management, emotional, and spiritual support tailored to meet the needs of individuals and their caregivers.

Intubation: The medical procedure of placing a breathing tube through the mouth or nose and down into the windpipe to keep airways open. The tube may connect to a machine that breathes for the patient (mechanical ventilation) if they are unable to breathe for themselves.

Life-Sustaining Treatment: Any medical care that artificially supports or replaces a bodily function essential to maintaining life, such as mechanical ventilation, dialysis, or artificial nutrition, which prolongs life but does not cure the underlying medical condition.

Mechanical Ventilation: A form of life-support that helps you breathe or breathes for you when you are unable to breathe on your own.

Opioid: A class of medications used to treat moderate to severe pain and other symptoms. Opioids are commonly used in serious illness and at end of life to support comfort and quality of life.

Print Name: _____ Date: _____ Page 11 of 12

Organ Donation: The act of taking organs, tissue, or blood from a living or deceased person and giving them to another person or organization to save or prolong life, improve quality of life, or for research purposes.

Palliative Care: A specialized form of medical care focused on providing pain and symptom relief, as well as psycho-social and spiritual support for people living with a chronic illness to improve and/or maintain quality of life. Palliative care can be provided alongside curative treatment.

Permanent Vegetative State: (also known as unresponsive wakefulness syndrome) When a person is awake but shows no signs of awareness. The brain stem still functions, and the person can breathe without support, may respond to pain or loud noises, go through sleep-wake cycles, and display involuntary motions, such as tracking moving objects, swallowing, smiling, crying, moaning, or screaming, but they do not have self-awareness, emotions, cognitive function, or the ability to interact with others or their environment in a meaningful way. A person in a vegetative state for more than a year is in a permanent vegetative state with an extremely low chance of recovery.

POLST (Provider Orders for Life-Sustaining Treatment): A portable medical order, signed by a licensed provider, that communicates a patient's treatment preferences for end of life to health care facilities and providers, including emergency medical services. A POLST is a part of advanced care planning that compliments but does not replace a health care directive.

Terminally Ill: An irreversible or incurable medical condition expected to result in death.

TPN (Total Parenteral Nutrition): A form of artificial nutrition administered intravenously (through the vein) that bypasses the entire digestive system, allowing for complete calorie supplementation temporarily or permanently.