

Health Care Directive

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Allows you to name another person (called a health care agent) to make health care decisions if you are unable to do so. Health care agents must be 18 years or older.

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Allows you to give written instructions about what you want.

Part 3 — My Hopes and Wishes (Optional).....3

Allows you to make your wishes known to your designated agent(s).

Part 4 — Legal Authority.....7

Requires you and others to sign and date to make this document legal. Witnesses must be 18 years or older.

Part 5 — Next Steps.....8

Provides you with advice on next steps that you might want to consider.

If you are deaf or hard of hearing, please let us know. We provide many free services including sign language interpreters, oral interpreters, TTYs, telephone amplifiers, note takers and written materials.

Introduction

I created this document with much thought to give my treatment choices and personal preferences if I cannot communicate my wishes. I have also appointed a health care agent to speak for me. My agent is able to make medical decisions for me, including the decision to decline treatments I do not want.

My name:

My date of birth:

My address:

My home phone number:

My cell phone number:

My work phone number:

Who Has Copies of This Document

Primary (main) health care agent:

Burnsville Family Physicians
625 E. Nicollet Blvd * Suite 100
Burnsville, MN 55337

Main Number: 952-435-0303

Fax: 952-892-5166

Alternate health care agent:

Telephone (h) _____ Telephone (c) _____

Telephone (w) _____

Health care provider/clinic:

Telephone (h) _____ Telephone (c) _____

Telephone (w) _____

Telephone (h) _____ Telephone (c) _____

Telephone (w) _____

Telephone (h) _____ Telephone (c) _____

Telephone (w) _____

Part 1: My Health Care Agent

If I am unable to communicate my wishes and health care decisions due to illness or injury, or if my health care providers have determined that I am not able to understand my situation, I appoint the following person(s) to represent my wishes and make my health care decisions.* When choosing a health care agent, I have considered his or her ability to willingly make decisions while being aware of my treatment choices. This person can follow my wishes under times of stress.

My primary (main) health care agent is:

Name: _____

Relationship: _____

Telephone (h) _____ Telephone (c) _____

Telephone (w) _____

Address:

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I name as my alternate agent:

Alternate health care agent:

Name: _____

Relationship: _____

Telephone (h) _____ Telephone (c) _____

Telephone (w) _____

Address:

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I want my health care agent to:

- make choices for me about my medical care. This includes tests, medicine and surgery. If treatment has already begun, my agent can continue it or stop it based on my instructions.
- interpret any instruction I have given in this form according to his or her understanding of my wishes, values and beliefs.
- review and release my medical records and personal files as needed for my medical care.
- arrange for my medical care and treatment in Minnesota or any other state or location he or she thinks is appropriate.
- decide which health providers and organizations provide my medical treatment.

Comments or restrictions on the above:

**I understand that my agent cannot be a health care provider or employee of a health care provider giving direct care to me. Exceptions: I am related to that person by blood, marriage, registered domestic partnership or adoption, or provide a clear reason why I want that person to serve as my agent. If my agent is a health care provider or an employee of a health care provider, my reason for choosing him or her is:*

Part 2: My Health Care Directives

My choices and preferences for my health care are as follows. I ask my agent to represent them, and my doctors (and/or health care team) to honor them, should I become unable to communicate my wishes. ***I have initialed the option below that I prefer for each circumstance.*** (Note: You do not need to provide written instructions about treatments to extend your life, but it is helpful to do so. If you choose not to, your health care agent will make decisions based on your spoken directions or on what is considered to be in your best interest.)

1. Treatments to prolong my life

If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to interact meaningfully:

_____ I want to **stop or withhold all treatments** that are prolonging my life. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), CPR and antibiotics.

OR

_____ **I do want** all appropriate treatments recommended by my doctor, until my doctor and agent agree that such treatments are harmful or no longer helpful.

With either choice I understand I will continue to receive pain and comfort medicines, as well as food and fluids by mouth if I am able to swallow.

Comments or directions to health care providers:

2. Cardiopulmonary resuscitation (CPR)

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

_____ **I do not want CPR** attempted if my heart stops, but rather want to permit a natural death.

OR

_____ **I want CPR attempted unless** my doctor determines **any** of the following:

- I have an illness with no cure or injury and am dying.

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- I have no reasonable chance of survival if my heart or breathing stops.
- I have little chance of long-term survival if my heart or breathing stops, and the process of resuscitation would cause significant suffering.

OR

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

Part 3: 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 choices about specific medical treatments, if any (this could include your wishes regarding ventilators, dialysis, antibiotics, tube feedings, etc.):

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

5. 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.):

6. My spiritual or religious beliefs and traditions:

I am of the _____
faith and am a member of the _____

_____ faith community in (city)
_____.

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Please attempt to notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

7. Organ donation (leave blank if you have no preference):

_____ **I do want to donate** my eyes, tissues and/or organs, if able. My specific wishes (if any) are: _____

OR

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

8. Other wishes/instructions:

Part 4: Legal Authority

Under Minnesota law, you must have this document signed and dated in the presence of two witnesses **or** a notary public.

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:

Signature: _____

Date: _____

Statement of witnesses:

I personally witnessed the signing of this document. I certify that I am not appointed as a 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: _____. At least one witness cannot be a provider or an employee of the provider.

Witness Number One:

Signature: _____

Date: _____

Print name:

Address:

Witness Number Two:

Signature: _____

Date: _____

Print name:

Address:

OR

Notary Public:

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:

Part 5: Next Steps

Now that you have completed your health care directive, you should also take the following steps. This page is not part of your health care directive.

- Tell the person you named as your health care agent, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future.
- Give your 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. Make sure your wishes are understood and will be followed.
- Keep a copy of your health care directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of your health care directive 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.

If your wishes change, fill out a new health care directive form and tell your agent, your family, your doctor and everyone who has copies of your old health care directive forms.

Advance Care Planning Glossary

Advance Care Planning (ACP): A process in which health care professionals help you understand your medical conditions, potential complications, and options for future medical care. Professionals will help you communicate your choices and thoughts to family, loved ones, and health care providers. As part of this process, you will be encouraged to think about how your values, goals, beliefs and culture affect your health care choices.

Antibiotics: Antibiotics are medications that are designed to kill germs that cause infections. Near the end-of-life, they may be used to treat pneumonia, blood infections and other serious infections. Antibiotics are not helpful against common colds and intestinal infections caused by viruses, so their use is saved only for times where they may really help a sick patient.

Artificial nutrition and hydration: The placement of nutrients and fluids into the stomach, intestine or veins. You may receive artificial nutrition and hydration when you can no longer eat or drink on your own.

Cardiopulmonary Resuscitation (CPR): Treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions, medicines, electrical shocks and a breathing tube.

Decisional capacity: The ability to make choices for yourself. Some people are not able to make decisions when they are very sick or as they grow older.

Dialysis: Dialysis is a mechanical way to do the work your kidneys normally do. It cleans your blood by removing wastes and extra water. It helps control blood pressure and helps your body keep the proper balance of chemicals such as potassium, sodium, and calcium.

Do Not Intubate (DNI): If your breathing stops, caregivers will not insert a tube to assist your breathing. You will be offered the option of comfort care.

Do Not Resuscitate (DNR): If your breathing or heartbeat stops, care givers will not try to start your breathing or heart beat.

Health care agent: A person you choose to make your health care decisions if you are unable to do so.

Health care directive: Also known as advance directive or living will, a health care directive includes written instructions about your future medical care. It also names a health care agent.

Hospice: If you are ill and have a life expectancy of six months or less, hospice is a choice you may consider. Hospice care tries to improve quality of life and increase dignity. Hospice care looks at your social, emotional, and spiritual needs as well as your physical needs. Hospice services can be provided in your home or in a facility of your choosing.

Intravenous fluids (IVs): Liquid fluids that go into your veins through a small tube (catheter).

Intubation: Placement of a tube into the nose or mouth to help you breathe when you cannot breathe for yourself.

Life sustaining treatment: Any treatments that prolong life including CPR, ventilators, dialysis, antibiotics and intravenous fluids (IVs).

Palliative care: Palliative care aims to relieve suffering and improve quality of life for patients with advanced illness and their families. Palliative care services are provided by a team of caregivers that includes physicians, nurses, social workers and chaplains.

Provider Orders for Life Sustaining Treatment (POLST): POLST is a medical order form signed by a doctor that documents your end-of-life health care wishes to other health care providers during an emergency. The POLST translates a health care directive into medical orders.

Respirator/Ventilator: This machine pumps air into your lungs and breathes for you. You are not able to speak when you are on a ventilator.

POLST: Provider Orders for Life Sustaining Treatment

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders, THEN contact the patient's provider.

This is a provider order sheet based on the patient's medical condition and wishes. POLST translates an advance directive into provider orders. Any section not completed implies the most aggressive treatment for that section. Patients should always be treated with dignity and respect.

CPR/ATTEMPT RESUSCITATION DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

COMFORT CARE — Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.

Check all that apply:

- Avoid calling 911, call _____ instead
- If possible, do not transport to ER (EMS should consult medical control)
- If possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS — Provide interventions aimed at treatment of new or

reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited.

Check one:

- Do not intubate
- Trial of intubation (e.g. _____ days) or other instructions:

-
- Intubate long-term if necessary

PROVIDE LIFE SUSTAINING TREATMENT

Intubate, cardiovert, and provide medically necessary care to sustain life.

Additional Orders (e.g. dialysis, etc.)

Additional Orders:

ANTIBIOTICS (check one):

- No Antibiotics (Use other methods to relieve symptoms whenever possible.)
- Oral Antibiotics Only (No IV/IM)
- Use IV/IM Antibiotic Treatment

NUTRITION/HYDRATION (check all that apply):

- Offer food and liquids by mouth
- Tube feeding through mouth or nose
- Tube feeding directly into GI tract
- IV fluid administration
- Other:

E

THESE ORDERS REFLECT THE PATIENT'S TREATMENT WISHES

Name Date

Relationship to Patient Phone Number

Signature

D

Check

All That

Apply

SUMMARY OF GOALS

SIGNATURE OF PATIENT OR HEALTH CARE AGENT / GUARDIAN / SURROGATE

Minnesota POLST — June, 2010

PATIENT

NONE

HEALTH CARE AGENT:

COURT-APPOINTED GUARDIAN

PARENT(S) OF MINOR

OTHER:

REQUEST

KNOWN PREFERENCE

**HEALTH CARE DIRECTIVE/
LIVING WILL**

BEST INTEREST

OTHER:

DISCUSSED WITH: THE BASIS FOR THESE ORDERS IS PATIENT'S (check *all* that apply):

COMPLETING POLST

- Must be completed by a health care professional based on patient preferences and medical indications.
- If the goal is to support quality of life in last phases of life, then DNR must be selected in Section A.
- If the goal is to maintain function and quality of life, then either CPR or DNR may be selected in Section A.
- If the goal is to live as long as possible, then CPR must be designated in Section A.
- POLST must be signed by a physician, nurse practitioner, Doctor of Osteopathy, or Physician Assistant (when delegated) to be valid.

USING POLST

- Any section of POLST not completed implies most aggressive treatment for that section.
- An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort.
- An IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only".
- Artificially-administered hydration is a measure which may prolong life or create complications. Careful consideration should be made when considering this treatment option.
- A patient with capacity or the surrogate (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.
- **Comfort care only:** At this level, provide only palliative measures to enhance comfort, minimize pain, relieve distress, avoid invasive and perhaps futile medical procedures, all while preserving the patients' dignity and wishes during their last moments of life. This patient must be designated DNAR status in section A for this choice to be applicable in section B.
- **Limit Interventions and Treat Reversible Decisions:** The goal at this level is to provide limited additional interventions aimed at the treatment of new and reversible illness or injury or management of non life-threatening chronic conditions. Treatments may be tried and discontinued if not effective.

• **Provide Life-Sustaining Care:** The goal at this level is to provide limited additional interventions aimed at the treatment of new and reversible illness or injury, or management of non life-threatening chronic conditions. Treatments may be tried and discontinued if not effective.

REVIEWING POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

1. The patient is transferred from one care setting or level to another, **or**
2. There is a substantial change in the patient's health status, **or**
3. The patient's treatment preferences change.

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

TO VOID THIS FORM, DRAW A LINE ACROSS SECTIONS A - D AND WRITE "VOID" IN LARGE LETTERS.