STEVENS COMMUNITY MEDICAL CENTER
Morris, MN 56267 (320)589-1313

HEALTH CARE DIRECTIVE (MINNESOTA)

Patient Name:

Date of Birth:

Name: _____ **Date of Birth:** _____

Address: _____ **Social Security #** _____

_____ **Phone:** (Home) _____

(Work) _____

AGENT DUTIES

My health care agent may:

- Make health care decisions for me if I am unable to make and communicate decisions for myself.
- Make decisions based on any instructions given in this document.
- Make decisions based on what he or she knows about my wishes.
- Act in my best interests if instructions are not available

If I am unable to decide or speak for myself, my agent has the power to:

- Consent to, refuse, or withdraw any health care which is keeping me alive and decide about intrusive mental health treatments.
- Choose my health care providers.
- Choose where I live when I need health care and what personal security measures are needed to keep me safe.
- Review and obtain copies of my medical records and determine who else can.

I appoint the following person(s) as my Health Care agents(s) to make any health care decisions for me when, in the judgment of my attending physician, I am unable to make or communicate the decision myself and when my agent consents to make or communicate the decision on my behalf.

Health Care Agent

Name _____

Address _____

Phone(s) (Home) _____

(Work) _____

Relationship _____

Alternate Health Care Agent (optional)

Name _____

Address _____

Phone(s) (Home) _____

(Work) _____

Relationship _____

REASONS FOR NAMING A HEALTH CARE PROVIDER AS MY AGENT (if necessary)

I have named, as my agent, a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed. That person is not related to me by blood, marriage, registered domestic partnership, or adoption. My reason for wanting to appoint that person as my agent are:

_____

_____

Routing: Scan into ChartMaxx (Health Care Directive/Code Status - S) → Create FYI Flag in EPIC → Mark received in Demographics/Advance Directive

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Patient Name:

Date of Birth:

I GIVE THE FOLLOWING INSTRUCTIONS ABOUT MY HEALTH CARE:

❒ No special instructions

OR

CPR ❒ Yes ❒ No

Yes	No	**Reasonable** Chance of Recovery	Yes	No	**No Reasonable** Chance of Recovery
❒	❒	Breathing Machine (Ventilator)	❒	❒	Breathing Machine (Ventilator)
❒	❒	Feeding Tube	❒	❒	Feeding Tube
❒	❒	IV Fluids	❒	❒	IV Fluids
❒	❒	Surgeries	❒	❒	Surgeries
❒	❒	Dialysis	❒	❒	Dialysis
❒	❒	Antibiotics	❒	❒	Antibiotics
❒	❒	Blood Transfusions	❒	❒	Blood Transfusions
❒	❒	Pain relief even if it affects my alertness or unintentional shortens my life	❒	❒	Pain relief even if it affects my alertness or unintentional shortens my life

Other Instructions

_____

_____

_____

MY PREFERENCE FOR CARE WHEN DYING

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

❒ At home_____

❒ At a hospital. Which one? _____

❒ At a nursing home. Which one? _____

❒ Through hospice services/care. Which one? _____

❒ From other health care providers. Which one? _____

❒ I would like to have as my doctor. _____

Other wishes I have about my care if I am dying

_____

_____

- I am attaching additional instructions concerning my health care values and preferences. ❒ Yes ❒ No
- I authorize donation of organs, tissue, or other body parts after my death. ❒ Yes ❒ No
- The following are my wishes regarding my body after I die:
  ❒ burial ❒ cremation ❒ autopsy ❒ other _____

Patient Name:

Date of Birth:

Signature Page

As of this date, I understand my condition, I understand treatment that is available, and I am able to communicate my choices.

I revoke all Living Wills, Durable Powers of Attorney for Health Care, or other written advance health care directives I have signed in the past.

I understand and agree with everything in this document and have made this document willingly.

IN WITNESS WHEREOF, I have hereunto signed my name this _____day of _____, _____

_____
My Signature

OPTION #1
STATE OF MINNESOTA. COUNTY OF_____

The foregoing instrument was signed or acknowledged before me this _____ day of _____, _____. I am not the agent or alternative agent appointed in the foregoing instrument.

_____
Notary Public

OR

OPTION #2 ***NOTE: ONLY ONE WITNESS MAY BE A HEALTH CARE PROVIDER. NO WITNESS MAY BENEFIT FINANCIALLY FROM THIS PERSON'S DEATH.***

I certify that I am at least 18 years of age and that I am present on the date appearing above the signature of the person executing this document, _____. He/She signed or acknowledged the signing of this document. I am not named as agent or alternative agent in this document. If I am a health care provider (or an employee of a health care provider) administering direct care to the principal on the date appearing above, I have so noted below.

Witness _____
Address _____
Health Care Provider? ❒ Yes ❒ No
Witness would benefit financially from this person's death? ❒ Yes ❒ No
Witness _____
Address _____
Health Care Provider? ❒ Yes ❒ No
Witness would benefit financially from this person's death? ❒ Yes ❒ No

Please keep the original for yourself and distribute copies to the following as applicable: ❒ hospital, ❒ clinic, ❒ Home Care Agency, ❒ agent, ❒ alternative agent, ❒ other children, ❒ close relatives who need to know.