145C.16 SUGGESTED FORM.

The following is a suggested form of a health care directive and is not a required form.

HEALTH CARE DIRECTIVE

I, ..., understand this document allows me to do ONE OR BOTH of the following:

PART I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS

FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent)

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

When I am unable to decide or speak for myself, I trust and appoint ..... to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me:.....

Telephone number of my health care agent:.....

Address of my health care agent:.....

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint ..... to be my health care agent instead.

Relationship of my alternate health care agent to me:.....

Telephone number of my alternate health care agent:.....

Address of my alternate health care agent:.....

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO

DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

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

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

.....

.....

.....

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

..... (1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

..... (2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

.....

.....

.....

PART II: HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:.....

.....

.....

My fears about my health care:.....

.....

.....

My spiritual or religious beliefs and traditions:.....

.....

.....

My beliefs about when life would be no longer worth living:.....

.....

.....

My thoughts about how my medical condition might affect my family:.....

.....

.....

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

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

I have these views about my health care in these situations:

(Note: You can discuss general feelings, specific treatments, or leave any of them blank)

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:.....

.....

.....

If I were dying and unable to decide or speak for myself, I would want:.....

.....

.....

If I were permanently unconscious and unable to decide or speak for myself, I would want:.....

.....

.....

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:.....

.....

.....

In all circumstances, my doctors, advanced practice registered nurses, or physician assistants will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:.....

.....

.....

There are other things that I want or do not want for my health care, if possible:

Who I would like to be my doctor, advanced practice registered nurse, or physician assistant:.....

.....

.....

Where I would like to live to receive health care:.....

.....

.....

Where I would like to die and other wishes I have about dying:.....

.....

.....

My wishes about donating parts of my body when I die:.....

.....

.....

My wishes about what happens to my body when I die (cremation, burial):.....

.....

.....

Any other things:.....

.....

.....

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

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

.....

My Signature

Date signed: .....

Date of birth: .....

Address: .....

.....

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

.....

Signature of the person who I asked to sign this document for me.

.....

Printed name of the person who I asked to sign this document for me.

Option 1: Notary Public

In my presence on ..... (date), ... (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

.....

(Signature of Notary) (Notary Stamp)

Option 2: Two Witnesses

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

Witness One:

(i) In my presence on ..... (date), ... (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

.....

(Signature of Witness One)

Address: .....

.....

Witness Two:

(i) In my presence on ..... (date), ... (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

.....

(Signature of Witness Two)

Address: .....

.....

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, advanced practice registered nurses, physician assistants, family, close friends, health care agent, and alternate health care agent. Make sure your doctor, advanced practice registered nurse, or physician assistant is willing to follow your wishes. This document should be part of your medical record at your physician's, advanced practice registered nurse's, or physician assistant's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

History: *1998 c 399 s 24; 1999 c 14 s 1; 2020 c 115 art 4 s 72; 2022 c 58 s 83*