Wishes for Health Care: Short Form

Advance [Health Care] Directive

See completion form for directions

I have completed this Advance Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent to speak for me if I cannot communicate or make my own health care decisions. I understand I may complete: 1) both Sections 1 and 2 below; or 2) only Section 1; or 3) only Section 2.

Full Name: _____ Date of birth: _____

1. **I appoint the following person to serve as my primary (main) health care agent. An agent is also known as a power of attorney.** This person will make health care decisions for me if I cannot communicate or make these decisions myself:

   Name _____ Relationship _____

   Cell phone _____ Other phone _____

   (*Optional):* **I appoint the following person as my alternate health care agent** in the event my primary health care agent is not available:

   Name _____ Relationship _____

   Cell phone _____ Other phone _____

2. **I give the following instructions about my health care** (my values and beliefs, what I do and do not want, views about specific medical treatments or situations including whether or not I wish to receive artificial nutrition and hydration):

   Cardiopulmonary Resuscitation (CPR): If I have no pulse and am not breathing.

   CPR/Attempt Resuscitation DNR/Do Not Attempt Resuscitation (Allow Natural Death)

   Medical Interventions: Comfort measures will always be provided regardless of level of care chosen.

   Full Treatment: Use all appropriate medical & surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

   Limit Interventions & Treat Reversible Conditions: Provide interventions aimed at treatment of new or reversible illness/injury or no-life threating chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Avoid intensive care.)

   Comfort Measures Only: Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. I prefer no transfer to the hospital for life-sustaining treatments, transfer if comfort needs cannot be met in my current location. If possible and I can be made comfortable at my residence do not transport to the ER and do not admit to the hospital from the ER.

   Additional preferences (i.e. related to dialysis or other medical interventions).

   Long-term nutrition by tube. Defined trial period of nutrition by tube. No artificial nutrition by tube.

   Additional preferences (i.e. related to dialysis or other medical interventions).

   Additional preferences or instructions to my agent(s):

Legal Authority

I have made this document willingly. I am thinking clearly. This document states 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 *(of person asked to sign)* **Date**

_____

Printed Name

Note: This document must be notarized or witnessed. Two witnesses OR a Notary Public must verify your signature and the date.

Option 1: Notary Public

State of **_____,** County of _____

Notary seal

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.

_____

Signature of Notary

My commission expires: _____

Option 2: Statement of Witnesses

Witness 1: In my presence on _____ (date), _____ (name) voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf).

_____ _____

Signature **Date**

_____

Printed Name

Witness 2: In my presence on _____ (date), _____ (name) voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf).

_____ _____

Signature **Date**

_____

Printed Name

Acceptance of Appointment of Agent/Healthcare Power of Attorney (ND)

I accept this appointment and agree to serve as an agent for health care decisions. I understand I have a duty to act consistently with the desires expressed in this document and to act in good faith. This individual can revoke my designation as an agent at any time in any manner. I will notify this individual if I choose to withdraw from this role while this individual is competent. I will notify this individual's health care provider if I choose to withdraw from this role when this individual is not able to make health care decisions.

_____ _____

Signature of agent/date Signature of agent/date

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Completion directions

Do I have to complete this Advance Directive?

No. You may complete it today or at a later date, or you can decline to complete it. However, completing this form will help make sure you get the care you want. Putting your choices in writing helps loved ones know if they're doing what you would want.

What information am I being asked for?

Question 1: This question is about your health care "agent." An agent is also known as Healthcare Power of Attorney. Your agent is someone you choose to speak and make health care decisions for you if you cannot. Consider naming a family member or friend who knows you well and understands your values. **Showing your agent this document and talking about it with him or her is important.** Make extra copies to share with your health care agent, health care providers, and other important people in your life.

Question 2 *(Optional):* This question is about health care and other wishes you may have. You may be as specific or general as you like. You may include:

- your goals, values, and preferences about medical care
- the types of medical treatment you would want or not want
- how you want your agent or agents to decide
- where you would like to receive care (such as at home or a hospital)
- whether or not you would like to donate your organs, tissues, and eyes

Requirements for Witnesses by State

Iowa: Notary or 2 adult witnesses are required. A witness cannot be: (1) a provider attending the principal on the date this document is signed; (2) an employee of the provider attending the principal on the date this document is signed; (3) the Health Care Agent named in this document; and (4) at least one witness cannot be related to the principal by blood, marriage, or adoption within the third degree of relation.

Minnesota: Notary or 2 adult witnesses are required. A witness cannot be the health care agent or alternate health care agent. Of the two witnesses, only one can be a health care provider or an employee of a provider giving direct care on the date the document is signed.

North Dakota: Notary or 2 adult witnesses are required. A witness cannot be: (1) the Health Care Agent; (2) the principal's spouse or heir; (3) a person related to the principal by blood, marriage, or adoption; (4) a person entitled to any part of the Estate of the principal upon the death of the principal under a will or deed; (5) any other person who has any claims against the Estate of the principal; (6) a person directly financially responsible for the principal's medical care; or (7) the principal's attending physician. In addition, at least one witness may not be a health care or long term care provider providing direct care to the principal on the date this document is signed or an employee of a health care or long term care provider providing direct care to the principal on the date this document is signed.

South Dakota: Notary or 2 adult witnesses are required. A witness cannot be: (1) related to the signer by blood, marriage, or adoption; or (2) be a creditor of the signer nor entitled to any part of the signer's estate under a will now existing or by operation of law.

Montana: Two adult witnesses must observe your signing of the form and then sign the form themselves. This document does not have to be notarized. Friends, acquaintances, and business associates can serve as witnesses during the signing. While Montana law allows family members to be witnesses, you may choose not to have relatives as witnesses to avoid questions of impartiality.

What should I do after I complete this form?

Tell the people you named as your primary and alternate health care agents, if you have not already done so. Make sure they feel able to do this important job for you in the future. Give a copy of the completed form to your health care provider. Keep additional copies for your records and to share with your health care agents and family or others as you wish.

Who can I talk with if I have questions?

Your health care provider can answer your questions or concerns. He or she may refer you to an Advance Care Planning Facilitator for help.