SANFORD HEALTH

Advance Directive

Introduction

I have completed this Advance Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent (also known as Health Care Power of Attorney) to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

This document will replace any previous advance directive.

My name: _____ Date: _____

My date of birth: _____

My address: _____

My telephone numbers: (home) _____ (cell) _____

	My initials here indicate a professional medical interpreter helped me complete this document.

Part 1: My Health Care Agent (Also Known as Health Care Power of Attorney)

If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the person named below to communicate my wishes and make my health care decisions. My health care agent must:

- Follow my health care instructions in this document
- Follow any other health care instructions I have given to him or her
- Make decisions in my best interest and in accordance with accepted medical standards

Requirements for Who May Be an Agent or Health Care Power of Attorney Under State Law

Iowa: My agent cannot be a health care provider caring for me on the date I sign this document. My agent also cannot be an employee of a health care provider unless related to me by blood, marriage, or adoption within the third degree of relation.

Minnesota: My agent must be an adult. My agent cannot be a health care provider or employee of a health care provider giving me direct care unless I am related to that person by blood or marriage, registered domestic partnership, or adoption or unless I have specified otherwise in this document (Specify here: _____). In addition, a person appointed to determine my capacity to make decisions cannot be my agent.

North Dakota: My agent must be an adult. My agent cannot be: 1) my health care provider; 2) someone who is an employee of my health care provider but is not related to me; 3) my long term care services provider; or 4) someone who is an employee of my long term care services provider but is not related to me.

South Dakota: My agent must be an adult.

SANFORD HEALTH

Advance Directive

My Primary (Main) Health Care Agent Is:

Name: _____ Relationship: _____

Telephone numbers: (H)_____ (C)_____ (W)_____

Full address: _____

If my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate Health Care Agent.

My Alternate Health Care Agent Is:

Name: _____ Relationship: _____

Telephone numbers: (H)_____ (C)_____ (W)_____

Full address: _____

Powers of My Health Care Agent:

My Health Care Agent automatically has all the following powers when I do not have the capacity to make decisions and/or I am unable to communicate for myself:

A. Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, withdrawing or starting artificial nutrition and hydration (such as tube feedings or IV (intravenous) fluids), and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.

B. Interpret any instruction in this document based on his or her understanding of my wishes, values and beliefs.

C. Review and release my medical records and personal files as needed for my health care, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. Arrange for my health care and treatment in a location he or she thinks is appropriate.

E. Decide which health care providers and organizations provide my health care.

F. Make decisions about organ and tissue donation according to my instructions in Part 2 of this document.

Comments or limits on the above: _____

_____

_____

_____

_____

_____

This is the directive of (name):_____ Date Completed:_____/_____/_____

SANFORD HEALTH

Advance Directive

Additional Powers of My Health Care Agent:

My initials below indicate I also authorize my health care agent to:

☐ Make decisions about the care of my body after death.

If I live in North Dakota or Minnesota, my initials below indicate I also authorize my health care agent to:

☐ Continue as my health care agent even if our marriage or domestic partnership is legally ending or has been ended.

☐ Make health care decisions for me even if I am able to decide or speak for myself, if I so choose.

Part 2: My Health Care Instructions

My choices and preferences for health care are indicated below. I ask my Health Care Agent to communicate these choices, and my health care team to honor them, if I cannot communicate or make my own choices.

I have initialed a box below for the option I prefer for each situation.

Note: You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or in your best interest if your wishes are unknown.

A. Cardiopulmonary Resuscitation: A Decision for the Present

This decision refers to a treatment choice I am making today based on my current health. **Section C below (Treatments to Prolong My Life: A Decision for the Future)** indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization.

SANFORD HEALTH

Advance Directive

I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases or impaired functioning, or both. I understand that recovery from CPR can be painful and difficult.

Therefore (initial one)

☐ I want CPR attempted if my heart or breathing stops.

Or

☐ I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed, then my agent or I (if I am able) should discuss CPR with my health care team. My choices in **Section B: Treatment Preferences and Section C: Treatments to Prolong My Life** below should be considered when making this decision. Examples of when my health has changed include:

- I have an incurable illness or injury and am dying
- 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 CPR would cause significant suffering.

Or

☐ I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand if I choose this option I should see my health care provider about writing a Do Not Resuscitate (DNR) order.

B. Treatment Choices: My Health Condition

My treatment choices for my specific health condition(s) are written here. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

_____

_____

_____

_____

_____

_____

_____

☐ My initials here indicate additional documents are attached.

This is the directive of (name):_____ Date Completed:_____/_____/_____

SANFORD HEALTH

Advance Directive

C. Treatments to Prolong My Life: A Decision for the Future

If I can no longer make decisions for myself, and my health care team and agent believe I will not recover my ability to know who I am, I want (Initial One):

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

☐ To **stop or withhold all treatments** that may extend my life. This includes but is not limited to artificial nutrition and hydration (for example, tube feedings and IV (intravenous) fluids), respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), dialysis, and antibiotics.

Or

☐ **All treatments recommended** by my health care team. This includes but is not limited to artificial nutrition and hydration (for example, tube feedings, IV (intravenous) fluids), respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), dialysis, and antibiotics. I want treatments to continue until my health care team and agent agree such treatments are harmful or no longer helpful.

Comments or directions to my health care team:

_____

_____

_____

D. Organ Donation (Initial One)

☐ I want to donate my eyes, tissues and/or organs, if able. My Health Care Agent may start and continue treatments or interventions needed to maintain my organs, tissues and eyes until donation has been completed. My specific wishes (if any) are:

_____

_____

_____

☐ I do not want to donate my eyes, tissues and/or organs.

Or

☐ My Health Care Agent can decide.

This is the directive of (name):_____ Date Completed:_____/_____/_____

SANFORD HEALTH

Advance Directive

E. Autopsy (Initial One)

☐ I want my agent to make decisions about an autopsy of my body.

☐ I do not want an autopsy unless required by law.

F. Comments or Directions to My Health Care Team

You may use this space to write any additional instructions or messages to your health care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ My initials here indicate additional documents are attached.

SANFORD HEALTH

Advance Directive

Part 3: My Hopes and Wishes (Optional)

I want my loved ones to know my following thoughts and feelings.

The things that make life most worth living to me are:

_____

_____

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

_____

_____

My thoughts about specific medical treatments, if any:

_____

_____

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

_____

_____

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.)**:**

_____

_____

Religious affiliation:

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

_____ faith community in (city) _____.

I would like my Health Care Agent to notify my faith community of my death and arrange for them to provide my funeral/memorial/burial.

I would like my funeral to include, if possible, the following (people, music, rituals, etc.)**:**

_____

_____

Other wishes and instructions:

_____

_____

☐ My initials here indicate additional documents are attached.

This is the directive of (name):_____ Date Completed:_____/_____/_____

SANFORD HEALTH

Advance Directive

Part 4: Legal Authority

Do not sign unless the witnesses or notary are present.

Note: This document must be notarized or witnessed. [See individual state requirements on page 9]. Two witnesses OR a Notary Public must verify your signature and the date.

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_____

Option 1: Notary Public

State of _____ County of _____

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_____ **Notary Seal**_____

My commission expires: _____

Or

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_____

This is the directive of (name):_____ Date Completed:_____/_____/_____

SANFORD HEALTH

Advance Directive

Requirements for Witnesses by State

Iowa: Notary Public 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 Public 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 Public 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 Public or 2 adult witnesses are required.

This is the directive of (name):_____ Date Completed:_____/_____/_____

SANFORD HEALTH

Advance Directive

After Completing the Advance Care Plan

Now that I have completed this document, I will:

- ☐ Keep the original copy of this document where it can be easily found.
- ☐ Make several copies of this document and give to my:
  - Primary and Alternate Health Care Agents
  - Doctor and other health care providers
  - Health care facility (hospital, other) whenever I am admitted, and ask that it be placed in my medical record
- ☐ Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Health Care Agent is, and what my wishes are.

When to Review Your Advance Care Plan

It is common to review and update an advance care plan regularly. You may want to review it with your annual 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.

Copies of This Document Have Been Given To:

Primary (main) Health Care Agent (listed on page 2 of this document)

Name: _____ Telephone: _____

Alternate Health Care Agent (listed on page 2 of this document)

Name: _____ Telephone: _____

Health Care Provider/Clinic

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

If my wishes change, I will fill out a new form. I will give copies of the new document to everyone who has copies of my previous one. I will tell them to destroy the previous version.

Note: The optional state-specific advance directive forms (if applicable) are available upon request.

This is the directive of (name):_____ Date Completed:_____/_____/_____