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सामग्रीहरूको तालिका

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सुरु गर्देँ

अग्रिम स्थाययोजनाको निर्णायनको महत्त्वपूर्ण छ?

अग्रिम स्थाययोजनाले तपाईंको स्वास्थ्यको गुण र तपाईंको उपचारको क्षमता बढाउनुको कारणमा तपाईंको लागि स्थाययोजनाले तपाईंका पीडा कम गराउन सक्छ।

मलाई अग्रिम स्थाययोजनाले तपाईंको लागि आवश्यक छ?

• तपाईंको इच्छा हरूसँग स्पष्ट रूपमा व्यक्त गर्नुहुन्तै
• तपाईंको स्वास्थ्यको उपचारको क्षमता सहजकताले तपाईंको प्रवेश गर्नुहुन्तै
• तपाईंको पर्वारलाई तथ्यार लागि मदद गर्नुहुन्तै

• तपाईंको जीवनस्थल र उपचारको क्षमतालाई आपूर्ती सामान्यता गर्नुहुन्तै
• तपाईंकी सुविधालाई मान्नुहुन्तै

• "थयदर्मा शाकाहारी बनाउनु हुनुहुन्तै
• "कुनै छैनतै
• "मलाई जीवन सम्बन्धमा घाइतै

• "थयदर्मा बनाउनु हुनु हुनुहुन्तै
• "कुनै छैनतै
• "मलाई जीवनस्थल र उपचारको क्षमतालाई आपूर्ती गर्नु हुनुहुन्तै
• "तपाईंकी सुविधालाई मान्नु हुनुहुन्तै

1B 9:µ 4B 2B <0L ,B<_2 µB=B 4B0 ,B |E.µ h
स्वास्थ्य स्याहार एजेन्ट छनोट गर्नुहोस्

तपाईंको स्वास्थ्य स्याहार एजेन्टको कत्यव्यभिचक्क तपाईंको स्वस्थ्य स्याहार इच्छाहरू पालना भएको छ।

• थ्यदर्थमा लाग्ने इच्छा राख्नुअघि तपाईंका लाग्ने तपाईंको एजेन्टले तपाईंको चचग्कत्सकले स्वास्थ्य स्याहार ग्नर्यथ्यहरू पनि बनाउने हुने छ।

• नोट: स्वास्थ्य स्याहार एजेन्टको लाग्ने कानुनी आवश्यकताहरू राज्य अनुसार फरक हुन सक्छ।

एजेन्ट छनोट गर्नका लागि सुझावहरू

• (B) ºB93 ³B=4K ¹B=(6K,ødE,B),Eµµ

• (B.K ³/5B<,.-aÖ 0!E=O<O

• (Bµ 00,,<Σ *B.(Bµ (µ 0B≠O;K

• (Bµ 0B=6B <o2B,_,E≠O<O

बैकलिप्य एजेन्ट छनोट गर्नुहोस्

3* (.B) =6040 B 93 .*Bµ6$ L, 1,K K #0 6B_*00-aÖ ,0# ,Eμ4BO_9B4 =O h K #,O# 4K.a ,AO K #6B k #;EO c ø2K 9B4D4B4B,B4D ^"B 6B_ CE .G52B=KQ &Q, 9B /O#D ,µ 1!E=O<O

North Dakota मा बस्ने मानिसका लागि

ND 2B, (Bµ K #) (Bµ K #6लिखित रूपमा <=2( ,µ h (.Bµ K #=6K.G59 O 10 2B_2

कानुनी फाराम भर्नुभएको सम्बन्धित एजेन्टहरू, उनीहरूको ठेगानाहरू तथा फोन नम्बरहरू सूचीबद्ध गर्न यो स्थान प्रयोग गर्नुहोस्।
मेरो स्वास्थ्य स्थायार्थ एजेंटका लागि सन्देश

2L6KB 8 2K 4JB 93 8B=B 4K #O!B B 6B ,O # 4K Oeh 8B B 83 8B=B 4K # -aO =O<6B 2K 4O B 4 iB=iO 0B 4KB 8B=B 4 9B1*B 6&ça_α <=6K _,'β 4K.a 2 A _,'β=ε, μ <Σ,h
(.B 8K 2K 4K 8K 2 9=1F.' 1,4a<ɜ, 93 h 26B 2K 4O #=#O 0B 4K 8B: E 8B , μ 93 = K
2L 6K 8B=B=E0;B2BK 4JB=B 4O 2#O=ε 6K 930;B 0,BO Eh 2L 6KB 8B 30 ,B O _ (a6_. *kh
2K 4O #E1O2B +39B*h

tपाई के गर्न सबनुसा

K #OK μ ,<Σ,Ei K ,μ <Σ,Ei 1!K 0B 4K 02B 4B 8B 4B B1! h <B) , =B2D 6KB 4O=E,B,E 4B B ,ō 4L <B B 2Κ B 8B 93 8B=B 4#B 3 ,O #, μ
• 2Κ 4XB B 8E+B 42B <=2_(a64 .B 4 4O$)
• 2Κ 4XB %64K%μ i 4E6B<,B,μ
• 2BO 6E ΩB=K 2B <B,μ 2Κ B 8B 93 8B=B 4#B 3 ,O #, μ
• 3)B 2L 6K 4O2 8B=B 8O ;B 2B" 6K ,*B=μεo 2. 0#B #B 2B 6B _ ,E 4O+, μ 42K 4O=ε *B ,μ
2K 4EB 93 8B=B 4K #E6K(.B 8B 2K 4O<,B,b' ,μ 42K 4O6O c Ωe2K 9B #8O 1*8L,h

आफेलाई सोच्नेमा प्रश्नहरु

• 2 3O1F`2B _1B, 4 4*B 3D 9 a6, E E i
K 26B 1_9=3O 8B B 83 8B=B 4B 6B _ 2B _,<=#O iB )B=B ?
• 2Κ 4O#B 4=ε b1! 1 (B _ , 2L 6K` 6 4O<q1!K B =K O-aO 6B _ 2L 6K`β=ε a6, <Σ ?
3D2KL _, 12B (.B 9B 98B E=O,F 1,K (B 8B a (B =ζOB 4E 4B 8B,D,E μO<
तपाईंको लागि राम्नरोसँग बाच्नुको अर्थ के हो विचार गरुँहोस्

आफ्नो विचार र मानहरू प्रतिविधिक गरुँहोस्

1. $3^*(B \oplus K < B \cup L)$ $4B < \varnothing$, $_0(B,E \quad 10$ a) $301,K,\varnothing < \varnothing,2$ $\mu \text{ < } Q$ $\text{O}$ $\text{O}$ $E \mu \text{ < } E \quad 4B6 \mu$( $\mu$ ?

2. $(B \cap D)4$ $D,\text{P}(D=O < 2B,B,\mu E \text{ 4B6 } \lambda( \mu$?

3. $(B \cap C,K \text{ D9},2B + \mu _9/B < 9B3B \delta \text{O}(B \text{E } E,1F \text{ `2B` } _1B$ ?

4. $3^*(B \oplus B < B) \oplus 9B3B < 23B = \varnothing 1,K,\text{O}(D=K)$ $\text{Q}$ $4(B \cap 1_9-32 \text{E} \text{ 4B6 } \lambda 4B, \text{E}$ ?

5. $1_9-30 \text{ a} \Delta \text{ < B.B46B } 3B,2B \text{ 4B } \lambda \text{B.B3B 6B K } 10 \text{ B =,E}$ ?

6. $\text{a} \Delta \text{ < B3B } = 4 \text{B40B(4K} \varnothing _1, \text{B6B 6B(6K < 4D 1B9 } *_{\gamma}$ ?

7. $(B \cap a \Delta < B.B40 \text{ 6} \varepsilon 3 = \varnothing 6B \text{ 4B22B 3B, K c( ,B 6B D } \Delta \text{ D9, 6B2O } \beta 6B_{=} = 6K_{=} \text{g} \varnothing _1, \mu B =B,E}$ ? $<9 1<\varnothing 2_9(G2B3098B = \varnothing -B \text{E3B, E}= \text{OQ } h$

8. $(B \varnothing 6B_8 \text{ EBG } (2G3E \text{ RO }) <\Sigma$?
सम्भावित चिकित्सा उपचारहरूबाट थप जात्रुहोस्

CPR (कार्डियोपोल्मोनी रिसस्टेंस)

CPR # _9`+=0<6B 83 4/0<<66B2 _0 0 * 4K2B,(.D=+6B .E,<<E,= 3B<6B 6B _30 )4 h

• CPR 0 30 (.B 630 +%Q 0 * 1301,K.B<6B .E,<<E,B 6B _30 )4 h (.B)
  B(2B*0B,K 4 (.B) 2E2B /B K, =2B9K ih

• तपाईले ज्ञान नसकेको इन्तुभन्ने 30 )4 h E0 (.B /B<6D2B (.B) 2E 9B,B2B µ (4Bd0
  ih E0 /B<2K<4B(1K c #66n) 40 ) <2 2ka<6E00B # (B) /SO<2B9B % h

• इलेक्ट्रोनिक झट्का (डिफ्रिब्रिलेशन) (.B) B(2D2B B,B8%2Bµ (.B) 2E2B4230 !# Q.B,B, 30 )
  <2 3<6B(.B) 2E0%+Q,0 <<<(.F9B8B2B3B, 2( .µ <2

• अणिधिहरूले (B) 2E2B, <<E,B 2( .µ <2

CPR को परिष्कारे परिणामको हो?

CPR 6KD9, 0B, <4 <6B * 42 h (.B) 2K4,9B93 4406K)4'B22B 1B9 .B,µ<Σ CPR
,γ<ά =022K=B K9G, 2 O4 - aδ2B <E γB, 61 30 ,B23K 1 ,B 0B1,Qhu (.B) *2L 4B09B93
12B 4 CPR aL E<4K2B=6KB4OB 2 µ h:(B62B 30=EγB 61 5 ,B23K 1 ,B 0B1,Qhu (.B) B9K _
CPR O 9'+2B <2B<2B(= 3 )<5 <B4' ).9B93 <2B<2B(= ) <Σ CPR a 9B93 3B=B4,0B 6B
ICU ( #g 3 4 3E _ ,#2B3B=B4<2B9K ) < : 

• /B<2B =B3B,µ 1K c #6K #

• (B) ]492B ≥( 

• \( \sqrt {\ll} =9B 2 g\/= ≥( |K =)B9B,

मैले CPR का बारेमा भेलो निर्णय कसी को उल्लेख गर्न सक्छ?

:(B62B ,(.B)K (.B) a Δ < 4 3 9B93 3B=B4B3=46B _2 3B=B4B0 ,B2B,µ 9B(.B)
a6d( 30 ,B=0 6.6 ,4B *B<933 K β CPR ,EµK h (.B)K CPR ,µ ,O # 4K2Bनुपरस्थान
गर्नहुँदै(DNR) %a Δ <B4B 6KdO =0H,0B 2E4B/0<<66B2 µ 4K 2B0%µ46K CPR ,µ 9B93
3B=B4B36B 0H (B)β 3O ,β EL _ , <232B .1g(µ ,µ <Σ,Eih

मैले CPR गर्न नचाहेका को हुन्छ?

(.B) 2E4B%+Q, 4O ,K 4 (.B) BG _ ( 2G6K h (.B)B <E4b<4B] <h

भेलेट्रेट वा BiPap

1K c #6K # ≠B * K δ =D 2 _ =B9B9;B 6B _30 ,µ <h

• भेलेट्रेट # 2Ka<0<6K -a6B /B<2B µB 2( * h 2Ka<F02B O ,%O E (.B) ,B 9B
  2E0B#/B<6D2B B h (B)β L 6K /B<Κ ,B 6B _ +Κ4L04 )Ei 1K 3<6K(.B) /SO<2B=99K h

• BiPap (hi-level <B4B,β 9B3E2B0B9B 6K(.B) 2E 4,B220a63O <_/ # |K K < 2BU 2B µ (.B)
  /SO<2B=99K h
भेंटिलेटरहरू वा BiPap सँग सम्बन्धित सम्भावित सरोकारहरू

1. (B.B) ग्रंथ रुक्तक 34 3E_._._ICU) 2B=K4B=93 । ।<
2. (B.B) <E\(4 B, 9 B_B_2 B 4 B\)h B । ।<
3. 1Kc #6K#0 (B.B) /B<6D2B+B (B.B) 00" , । ।<
4. (B.B) : 4D4*#6D, 9B ।< ।<
5. BiPap 2B k=(K=9B,B) K #2B ।<

मलाई भेंटिलेटर वा BiPap चाहिदेन भने के हुन्छ?

3*.(B.B) L 6K 9B,B< K , ।<

मृगौला डायलिसिस

%B 3a6a<< .B ।<

हेमोडायलिसिस 6K/4 #3 40 ।

पेरिटोनियल डायलिसिस (PD) 1,KO 2G6P ।

अप्राकृतिक खापिन वा अप्राकृतिक हाइड्रेशन

( के हँस(नासोपायस्ट्रिक) 6B ,B ।

IV रेखा (अन्तर्श्वात) 4K,B ;B ।

कुृमिय खापिनको बारेमा सम्भावित चिन्ता

O d2=t=6K ।
यदि मैले कृत्रिम खानपिन छनोट गरे भने के हुन्छ?

BG _{\text{1}} ( B_{\text{1}} , 6\text{K} (.B{\text{3}}B \ 4\text{B}02 =\langle E < \mu \ K = \text{D} < 23\text{B} \ 6\text{B} \ D9,0 E ' \langle 4 \ < \ E + B , 2 ( , \mu < \text{3} \ast (.B{\text{3}} \ D9,0 \ B , c ) E i , 1, K , B 4\text{O} < 232\text{B} ) \langle \Sigma K = 2 \text{B} = \text{c} \ =, B O \ i \ < \text{H}

यदि मैले कृत्रिम खानपिन छनोट गरेल भने के हुन्छ?

3 \ast (.B{\text{3}} \ 2\text{E}B4\text{B} B * B ) \mu \text{a}_{\text{6}}, \langle \Sigma E i, 4\text{G} \ 2 B _{\text{1}}, \text{O} # , E # , 1, K , (B{\text{3}}) : 4\text{D}4_{\text{9}(B{\text{4D}} \ast i \mu = \text{G} E < i < 9( \ K = \text{D} \ast , 9B = \text{A}B 2\text{B}K h D9,0 \ B , c , L 1B ' + B : _{\text{0}}4\text{B}2\text{D} = \text{c} 6\text{B}E 2\text{B} 3(3\text{B}LO 9B _{\mu =} E < \ast , Q 1! 4E B ) B = \text{B} B *(B{\text{3}}B / \text{4} ) \langle \text{H}

कृत्रिम हाइड्रेस्शनको बारेमा सम्पन्न चिन्ताहरू

G _{\text{2}} = B K 6K ( B{\text{3}} : 4\text{D}4\text{B}K d 34B 2( , \text{c} , h 3 < K = B ( E ' B 4.E K = 2 \text{B} = \text{F} , i < \text{H} / O < E = \text{G} E < 2B \ 9 , (4 : B ) \mu = \text{a} \B 3B \B ) < \Sigma , < 0 B 4' 6K / B < K \mu < B, i \ 4 / B < B 2 B 2 D / K < 2 \text{B} \ 9 < \text{H}

०d_2 = c 6K E 0 < B # 2B 4\text{G} 9 4 < 2 ' \text{A} _{\text{1}}, < 2B 9K : \mu h

यदि मैले कृत्रिम हाइड्रेस्शन गर्ने छनोट गरे भने के हुन्छ?

G _{\text{2}} = B K 6K (.B{\text{3}} : 4\text{D}4\text{B}3 3 \text{B} = 2( , \text{c} , h 3 < K = D < 23B 6B _{\text{1}} < B ( 9B 0 \& B, 4 E ' 4 \ < E + B , \mu < \text{H} 3 \ast (.B{\text{3}} \ D9,0 \ B , c ) E i , 1, K , B 4\text{O} < 232\text{B} ) \langle \Sigma K = 2 \text{B} = \text{c} \ =, B O 10 K 4B \ 1 < \Sigma , E i h

यदि मैले कृत्रिम हाइड्रेस्शन छनोट गरेल भने के हुन्छ?

: ( (4 : B ) \# = 0, B : 4\text{D}4_{\text{9}(B{\text{4D}} \ast i \mu = \text{G} E < i < 9( K = \text{D} 2 \text{G} = \text{E} 2 \text{G} O,c 1B + K 404B 2D = \text{c} 6K B \mu = \text{E} < \ast, Q h

D9,0 \ e (2 \ast , = \text{c} 2B, \mu = \text{c} K 6K 2\text{G} + 2B 4 B 3 = c 0 B . 6B ^{4,1} \mu 2 ( , \mu < \text{G} 6K (B{\text{3}}B : B ( 4' 3B' 0 1B 9, B 0 < B O ) 0% < \text{H} 3 < 6K (B{\text{3}}B ( B{\text{3}} ) e (2 \# B + K 4 B 22 B . B 4, \mu 2 ( , \mu < \text{H}

हृदय उपकरणहरूको नियन्त्रिता

Δ 3B40. '2E \# _{\text{6}K # \langle \text{ICD} 9B0B 3B E K E 64 a < \# .4' = \text{c} ( I.VAD ) (B{\text{3}} \ 63 B 3 \mu < 2\mu , \mu = 30, \mu < h , B 9 < 2\text{B} , \langle \Sigma 0 (B{\text{3}} \ D4' 6B _{\text{1}} f = f , \mu , 4 B 0 B ) 4 E ( 2 \text{G} B < \text{H} 3 < 2 B 4 B _{\text{2}B , L 3 < 0 B 4\text{B}K ) \% B 4E \# 4B , B 4, 30, B 0 B, B, 2( , \text{c} , h

संक्रमणहरूको लागि एनिमेशनिक

=6K = 2G35B B < 49B83 40 (B a, \text{D} < B < 2\text{B} O B 4'6K 14, < 2'0 \ 14'2B 9, t. \text{c} , i h, f ) 4

< 2' = c B \ K = \text{D} * B = 4' = c ' 20_2B 4B40'3E(4E) h (B{\text{3}} \ D9,0 I B 4* B 93, 14'B 22 B + B 4(14 < 2'0 B 4, \text{c} , \mu < \Sigma , E i h c \# B 23O 11 = \text{c} 4B B = 43B 0 B\text{ik} < 2' = c B 4 , \text{c} ; ' + = c = 0 h 3 ;' + = c 1B 2 < 9B / 6 < 20'2' = c . B 4, \mu 30 J h 3D ; ' = + = c I V 2B \mu ( \times, 93 ) < \text{H}
पल्लोएतिथ्य स्वास्थ्य र हस्पाइस स्वास्थ्य

(\.B y =B 4 <4D =K4B 8A( μ B =E) 1!K0B 9B 1B =η 2B9K;μ <Σ,Ei h

पल्लोएतिथ्य स्वास्थ्य <E_9+B , 3B =B46$ 4B,K_9+ =O6B 1,K0 400 6 , 4 <B% K <Θ= Ν 40Σ 9B .B4 Kµ =O4D 4O .B 6BK 8O .=6O ^,*K d0B 8< 3O ,B O 8B 1B ]E µ h .(B y _ 6B20<23 0B9 .K <B ,E µO 1 , _, ABBa6 ^#1 3B =B46$ 4B, < h ." 6O 1#1 3B =B46K æ *B , ,μ <Σ

• 6B 4 3 6≥ =Φ 0B # 6B2

• (.B y 4 (.B 0 ṃ )J4B4 6B_ 1B9,B D 4 3B fO 2) μ

• ^6 # B4 _ , B =η 0B, 2( ,EµO <Q

हस्पाइस केयर B2D 6 2= =B b1 2, 9<,.K ≥B ]4B =€ 6B .6$ 4B,K 4B2*B 3D =K4B =O(4 =OΚ _ 9 £ 6≥ -988,, 4B ) :B (23 2G4 92G a D9, 2Bh (.B y ṃ ΦB 93 #įL 3B *B .]49B44 <B )D =€ < : B )μF 'μ <232B ]49(μ h = Β = K 346K" 6O ^#1 Κ 34 Å<6B 6B_ <FD0 <0L6B1=€ " , <Σ


• 6B , <O ξ 4 3 ,E,E4 )K4B.D =€

• 3B =B4B(9BÈ B 6B_ _9B2 .6$ 4B, 4B =4B =B4

• ,E =B,K,E '2 , ,B,B ,BK 4 3 -aO 9B93 93Ö =€ 2B 2( ,B 6B _ G =ΦB 93 <=3O =€

• +B9, 4 B,B (B 3B4, ' (B <=B 3(BB 6B_ a:b=( 93 <K 9=€

• 3B =B4B(BÈ B 6B_ :O 4B2;μ <η ( =B 3(Β <K 9B =€

अङ्क दान

A0 _ , β 0,B *B *B,0B 8O(Ö= € 6B_ 9B4, EρO <Q www.life-source.org 2B* (Β µE ΦO <Q(Ο.B Ø <9B4B6 É E2 .(2B 8B 1B =η 4B πE =O <Q h

• 2B a'6O23.b22B 1B 3000 1 *B 0& c2B_, <=€ 6KΛ 3B 4O.' B 6B_ (D ≥B ]44 =Κ B ,Q h

• Ω *B,6ΚΒ.Ø ]49B46B :O O _3B2B 2( ,μ <Σ h -a6Κ 60 ,B 2B_, <O D9, 0B, <Σ h

• (.B y K Ð =€ *B, *Bµ(Β y pry 9B.(B y ) ]49B46H : E" 6B πh h

• (.B y ṃ ΦB 93 98B =€ 1 (B_ , (B y K *B, ,μ <Σ,Ei h

• <OL2E π +2ÖK6O *B,0 <2) μ h

• Ω *K dΚL _, A8K`28 30 ,B =€6B 1B9 B , t h

• Ω *B, =€ OΑ3 4= ,Q h

तपाईको पूर्ण अशीरीर _9B 6B 6B 6B *B, *B æ" L/B 4B2 =2 93 ,μ <Σ h
ग्नम्न र्श्व्टा पृष्ठअग्रिम स्थ्याहार थ्योजनाका फाराम हुन्।

• थ्यी पृष्ठहरू भनु्यहोस्। तपाईं ग्तनीहरूलाई हातेपुस्तकामा छोड्न सक्नुहुन्दछ र ग्तनीहरूलाई आफ ले चाहेअनुसार मे्टाउन सक्नुहुन्दछ।

• हरेक पृष्ठको तल आफ्नो नाम, जन्दम र पूर््य रूपमा लेख्नुहोस्।

• तपाईंका साक्षीहरू रा नो्टरी स्व्यसाधारर् उपक्स्त नहुँर्ासम्म पृष्ठ 10 को 8 मा रहेको भाग 4 "कानुनी अमधकार" मा हस्ताक्षर नगनु्यहोस्।

• आफ्ना रेकड्यहरूका लाग्ग प्रग्तचलग्पहरू बनाउनुहोस् र परर्वारलाई साझा गनु्यहोस्।

• पूरा भएको फारामहरूलाई तपाईंको मेग्डकल रेकड्यमा राख्नका लाग्ग आफ्नो स््वास्थथ्य स्थ्याहार थ्योजना प्रर्ाथ्यक र पूरा गररएको अग्रिम स्थ्याहार थ्योजना फारामलाई के गनने भन्ेबारे जान्का लाग्ग पृष्ठ 10 हेनु्यहोस्।
My Advance Care Plan

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) __________

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

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

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

[Signature]

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

[Signature]
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.

The ACP of (को) ACP __________________________________________________ (print name) (_ # ,B2)
Birth Date (जन्म तिनि) ___________________ Completion Date (पूर्ण तिनि) __________________________
My Primary (Main) Health Care Agent Is:
मेरो प्राथमिक (मुख्य) स्वास्थ्य स्याहार एजेन्ट निम्न हो:

Name (B2): ___________________________ Relationship (को): ___________________________
Telephone numbers: (H) #66/0, α04: (H)________________________ (C (C))________________________
(W (W))________________________  
Full address (F48K B)________________________

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:
मेरो विकल्प स्याहार एजेन्ट निम्न हो:

Name (B2): ___________________________ Relationship (को): ___________________________
Telephone numbers: (H) #66/0, α04: (H)________________________ (C (C))________________________
(W (W))________________________  
Full address (F48K B)________________________

Powers of My Health Care Agent:
मेरो स्याहार एजेन्टको साम्थथ्य्य:

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.

The ACP of (को) ACP __________________________________________________ (print name) (क_ _B2)
Birth Date (जन्म मिलि) _________________ Completion Date (पूर्ण हुने मिलि) _________________
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:

________________________
________________________
________________________
________________________
________________________
________________________
________________________
Advanced Care Plan / अग्रिम स्याहार योजना

Additional Powers of My Health Care Agent:

2K 46Β 2ξ3μB = B4Κ #0 (J4O :aθ¢ :)

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

(6B 2K 46B4) 2ξ6Κ 2K 46Β 93 <9K #6B 7 , 'G ( Eμ 1!KΕ 4B0 Q ( * μ

Make decisions about the care of my body after death.

2402G Βα :4D4 0 3B = B40B4Κ9 = ε 0, B, E = O <Qh

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

2 North Dakota 9B.Minnesota 2B0Q 1,K (6B 2K 46B4 = ξ6Κ 22K 46Β 93 <9K #6B _ , 'G ( Eμ 1!KΕ 4B0 Q ( * μ

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

3^2 = B0 99B 9B4Κ 6Ε-BK *B 4DF.D θ.2B <2B A 'I * , 9B<2B A 10 1,K _ , 2K 46Β 93 3B = B4Κ #0 θ.2B B4D4B1E = O <Qh

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

3^2 2 Α _ , 'B L Β 9B, 9B4Κ 6Ε-K 00,' <F 1,K _ , 3^2 2L 68B<0 , μ , O# 4K1,D 2K 46Β _ 9B93 3B = B4Κ 'B = Β 0, B, E = O <Qh

Part 2: My Health Care Instructions

भाग 2: मेरा स्वास्थ्य स्याहार निर्देशनहरू

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.

9B93 3B = B4Κ 6Ε-B 2K 40D 6B 4B ) '2(B = Β ( 6 Ξ ( 4B , Qh 3* ς 2 <B 4 , μ 9B4Κ 40 B = Β 0, B, 'S _ , 1,K 2 Α 9B93 K #6B 3D4O B = Β <B 4 , μ 42K 46Β 93 3B = B4Κ #0 6D6B (D = 6B <2B , μ <OE,h

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

मैले हरेक स्थितिका लागि रूचाएको विकल्पका लागि तल एउटा बाक्स छोटै गरेको हु।

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.

The ACP of (को) ACP __________________________________________________________ (print name) (J # ,B2)

Birth Date (जन्म मिलि) __________________________ Completion Date (पूरा हुने मिलि) __________________________
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.

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 (बा)

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:

2 0EoE_ CPR 6KD9, OB, <E (4 3<6K<+KB2 *h= E2 E0_ 0EoE_ CPR 6KD-(@E B 6B B2 *h= O< E4B,(B2B0+ )_02B 4E64B B 3B B9E9h E 2 0EoE_ CPR OB #E:, BeAi, .D%B*EB9D $é _ <7h

Therefore (initial one)

व्यस्तकार (प्रारम्भिक)

[ ] I want CPR attempted if my heart or breathing stops.

2K 4B 9B/B <B < 0 * = 1,K 26B CPR 3B < B = h
• have an incurable illness or injury and am dying

• have no reasonable chance of survival if my heart or breathing stops

• have little chance of long-term survival if my heart or breathing stops and CPR would cause significant suffering

Or (वा)

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.
C. Treatments to Prolong My Life: A Decision for the Future
मेरे जीवन लम्ब्याउने उपचारहरू: भविष्यका लागि निर्णय

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):

यदि म अब आफ्नो लागि निर्णय गर्न सक्दिन र मेरो स्वास्थ्य व्यवस्था टोली र एजेन्टले म रो भनेर जात्र मेरो क्षमता पुनः प्राप्त गर्न सक्दिन भने विश्वास गर्नुहुन्छ भने, म (प्रारम्भिक) चाहिए:

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.

1. 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.

2. 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:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

The ACP of (को) ACP __________________________________________________ (print name) ((_ # ,B2)
Birth Date (जन्म मिति) ____________________ Completion Date (पूरा हुने मिति) ______________
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 (वा)

My Health Care Agent can decide.

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

मेरो स्वास्थ्य स्याहार टोलीलाई लागि टिप्पणी वा निर्देशनहरू

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.

The ACP of (को) ACP ______________________________ (print name) (_ # ,B2)
Birth Date (जन्म म्याति) ______________________ Completion Date (पूरा हुने म्याति) ___________________
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 I would like to die 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 community in (city) :

The ACP of (को) ACP ____________________________ (print name) (को) (को)

Birth Date (जन्म तिथि) ____________________________ Completion Date (पूर्ण हुने मिति) ____________________________
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.

Other wishes and instructions:

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 of 9]. Two witnesses OR a Notary Public must verify your signature and the date.

If I cannot sign my name, I ask the following person to sign for me:

The ACP of (को) ACP __________________________ (print name) (/ _ # ,B2)
Birth Date (जन्म तिथि) ______________________ Completion Date (पूरा हुने तिथि) __________________________
Option 1: Notary Public

In my presence on \( \text{State of } \text{County of } \) \( \text{Date} \), \( \text{name} \) \((B2)\) 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. \( \text{Notary Seal} \)

My commission expires \( \text{Date} \)

Option 2: Statement of Witnesses

Witness 1: In my presence on \( \text{Date} \), \( \text{name} \) \((B2)\) voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf. \( \text{Notary Seal} \)

Witness 2: In my presence on \( \text{Date} \), \( \text{name} \) \((B2)\) voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf. \( \text{Notary Seal} \)

The ACP of \((\text{print name})\) \( \text{Birth Date} \) \( \text{Completion Date} \)
Advanced Care Plan / अग्रिम स्वास्थ्य योजना

Acceptance of Appointment of Health Care Agent (Health Care Power of Attorney)

स्वास्थ्य स्वास्थ्य एजेंटको अपोइन्टमेंट स्वीकृति (स्वास्थ्य स्वास्थ्य अधिकारिकामा)

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. I understand 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.

Primary Agent Signature: ____________________________
Date: ____________________________
Printed Name: ____________________________

Alternate Agent Signature: ____________________________
Date: ____________________________
Printed Name: ____________________________

Required in ND (ND मा आवश्यक)

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.

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.

The ACP of (को) ACP ____________________________ (print name) ((_ # ,B2)
Birth Date (जन्म मिलि) ____________________________ Completion Date (पूरा हुँदै मिलि) ____________________________
After Completing the Advance Care Plan

Now that I have completed this document, I will:

2L 68OB B ( .F484K O #B , 2 _ , aE4B , ¬E :

- 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
    - B') 2 49L " $B93 $B=B4K #=#6B ^*,K
    - Doctor and other health care providers
      - a_Δ < 4 3 $B93 $B=B*B3=ζ
    - Health care facility (hospital, other) whenever I am admitted, and ask that it be placed in my medical record
      - 2 1,BμO $B93 $B=B4E_9+B86:(B6 , 3 ) 43<6B 2K 4K %64K %B4B7 , E40+ , ¬

- 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.

26B )D4 40 9B0 # 6B K 2B6π, i <Σ,2K2K 4B6 , 49B44 ,c B <B)D=ζ6B 2K 4B93 $B=B4K #O =042K 4B=ζ K K ,Q 1!K4B )B=B 1,D <E_ ,b( #= =B=ζ < E4B , ¬

The ACP of (को) ACP __________________________________________________ (print name) (को) ACP __________________________________________________ (print name) (को) ACP __________________________________________________ (print name)

Birth Date (जन्म मिति) __________________________ Completion Date (मृत्यु हुने मिति) __________________________
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**

Name: ___________________________ Telephone (###-###-####)

**Alternate Health Care Agent**

Name: ___________________________ Telephone (###-###-####)

**Health care Provider/Clinic/Hospital/Family Members**

Name: ___________________________ Telephone (###-###-####)

Name: ___________________________ Telephone (###-###-####)

Name: ___________________________ Telephone (###-###-####)

Name: ___________________________ Telephone (###-###-####)

Name: ___________________________ Telephone (###-###-####)

The ACP of ___________________________ (print name) (###-###-####)

Birth Date ___________________________ Completion Date ___________________________
If your wishes change, fill out a new form. Give copies of the new document to everyone who has copies of your previous one. Tell them to destroy the previous version.

The ACP of (को) ACP __________________________________________________ (print name) (

Birth Date (जन्म तिथि) __________________________ Completion Date (पूर्ति हुने तिथि) ________________
When You Want Help With Advance Care Planning
तपाईले अग्रिम स्याहार योजनाका साथ मद्दत चाहेँदा

Advance care planning gives you the chance to talk with others. Health care providers, family members and important others can help you explore options. For more information contact:

**Bemidji**
Advance Care Planning Program
Phone: (218) 333-6060
Email: acp.bemidji@sanfordhealth.org

**Bismarck**
Advance Care Planning Program
Phone: (701) 323-1ACP (1227)
Email: acp.bismarck@sanfordhealth.org

**Siuks Falls**
DeGroot Center
Phone: (605) 312-3520
Email: acp.siouxfalls@sanfordhealth.org