Honoring Choices®
MINNESOTA

This document replaces any health care directive made before this one.
This document doesn't apply to electroconvulsive therapy or neuroleptic medications for mental illness.
I will give copies to my health care agents and health care teams when completed.
I will make a new health care directive if my agents, goals, preferences, or instructions change.

My Full Name _____ **My Date of Birth** _____
My Address_____
My Cell #_____ **Home #**_____ **Work #**_____

My Health Care Agents

My health care agent is my voice if I can't make health care decisions for myself. I trust my agent to **be my advocate,** to **follow my instructions,** and to **make decisions based on what I would want**. My agents are at least 18 years old. If I chose my health care provider to be an agent, I have given my reason below.

Health Care Agent

Name_____Relationship to me_____
Address_____
Cell #_____ Home #_____Work #_____

First Alternate Health Care Agent -If my health care agent isn't willing, able, or reasonably available.
Name_____Relationship to me_____
Address_____
Cell #_____ Home #_____Work #_____

Second Alternate Health Care Agent- If my first alternate agent isn't willing, able, or reasonably available.
Name_____Relationship to me_____
Address_____
Cell #_____ Home #_____Work #_____

Why I chose these health care agents: _____
_____

Health Care Agents: Powers and Special Situations

If I'm not able to make my own health care decisions, my health care agent can: access my medical records, decide when to start and stop treatments, and choose my health care team and place of care.

I also want my health care agent to:

Make decisions about continuing a pregnancy if I can't make them myself.
Make decisions about the care of my body after death (autopsy, burial, cremation).

Name_____ Date_____

My Future Care Preferences if I'm Permanently Unconscious

Permanent unconsciousness can be caused by an accident, a stroke, and other illnesses. My health care team may call

this a **permanent vegetative state.** This means the brain is so badly hurt that the person isn't aware of self or others, can't understand or communicate, and the health care team believes the person won't get better. Mechanical or artificial treatments may keep a person alive when the body can't function on its own. Examples are: ventilation (breathing machine) when the lungs aren't working, cardiopulmonary resuscitation (CPR) to try to restart a heart that has stopped beating, artificial feeding through tubes, intravenous (IV) fluids, and dialysis when the kidneys aren't working.

If I'm permanently unconscious:

I want some or all possible life-sustaining treatments if I'm permanently unconscious. My health care agent should work with my health care team to make decisions about treatments based on my goals and values. ***OR***

I don't want life-sustaining treatments if I'm permanently unconscious.

Focus on making me comfortable and allow natural death.

OR

I can't make a decision now about life-sustaining treatments if I'm permanently unconscious. My health care agent should work with my health care team to decide whether or not to use life-sustaining treatments based on my goals and values.

Organ Donation

I want to donate my eyes, tissues and/or organs, if I can. My health care agent may start and continue any treatments needed until the donation is complete.

I don't want to donate my eyes, tissues and/or organs.

Additional Instructions

I have attached #_____ page(s) of additional instructions to this document.

Making This Document Legal

1. Sign and date: *My Signature* _____ *Date Signed* _____

2. Have your signature notarized OR verified by 2 witnesses

MINNESOTA NOTARY PUBLIC: County of _____(county name) NOTARY SEAL BELOW
In my presence on the date of _____(date notarized)
_____(person signing above)
acknowledged their signature on this document. I am not named as a healthcare agent in this document.

Signature of Notary _____

OR **STATEMENT OF WITNESSES:** I am at least 18 years old. I am not named as a health care agent in this document. Only one witness can be an employee of the health care system providing care to the person on this date.

*Witness # 1 Signature*_____ *Witness # 2 Signature*
_____ *Date Signed* _____ *Date Signed*
_____ Print Name _____ Print Name _____