HEALTH CARE DIRECTIVE WORKSHEET INSTRUCTIONS
PLEASE READ BEFORE FILLING OUT THE ENCLOSED WORKSHEET

The following document is a questionnaire. It is not the final, legal document. We are asking you to review the issues and provide information requested in the following pages.

You must name at least one Health Care Agent and it is prudent to provide all of the contact information. More than one person can be named to serve together, but the more people who are involved, the more likely it is that there could be difficulties or delay.

You can also provide your views about the various issues brought out in the questionnaire. You are not required to respond to all the issues, only those about which you have a strong or definite opinion. We recommend you review the entire questionnaire before you begin actually writing in the document.

Check the boxes where you agree with the statement, and that statement will be included in your final Directive. Fill in the blanks with the text you want included in your final Directive.

The paragraph about nomination of a guardian on the first page is optional. If you do not want it included in your final document, cross out that paragraph.

The person or persons you name as your Health Care Agent must make health care decisions for you based on the instructions provided in your final document, keeping in mind the wishes you have made known to your Health Care Agent; or, in the absence of those instructions, your Health Care Agent must act in your best interests. Your instructions in the final document may also be used by your health care providers, others assisting with your health care, and by your family, in the event that you cannot make decisions for yourself.

DURABLE HEALTH CARE POWER OF ATTORNEY

As a Durable Health Care Power of Attorney, the final document shall be effective if you are ever determined to lack decision-making capacity by your personal physician or treating physician if you have no personal physician, or if your personal physician is unknown or is not reasonably available to participate. The Durable Health Care Power of Attorney shall be effective *only* in the event you lack decision-making capacity.

NOMINATION OF GUARDIAN

Should you ever need to have a guardian appointed by a court, you can nominate the person who is going to be your Agent, who is also willing and able to serve as your Agent, to be your guardian, in the event one is needed. This type of nomination applies to guardianship of your person only, and is not intended to nominate such person to handle personal finances, business affairs or other matters that have to do with information or property rights, other than as specifically and expressly authorized in this document.

☐ Check this box if you want your final document to also be a nomination of guardian of your person.

HIPAA PERSONAL REPRESENTATIVE

In responding to requests for information by your Health Care Agent, your medical care providers may rely on your Health Care Agent to also serve as your "personal representative" under federal "HIPAA" privacy laws (The Health Insurance Portability and Accountability Act and regulations thereunder) and any other State or Federal privacy laws. You should specifically provide for this authorization so that your Agent can gain access to confidential *medical* information about you so that they have the information needed to make an appropriate decision on your behalf. Such a designation of "Personal Representative" is not intended to confer nomination or appointment of a "personal representative" of your estate; it is not the same thing, even though the terms are identical. As such term will be used in your final medical document, it will only apply with regard to privacy laws.

☐ Check this box if you want your final document to also be a designation of "Personal Representative" , under federal "HIPAA" privacy laws (The Health Insurance Portability and Accountability Act and regulations thereunder) and any other State or Federal privacy laws regarding medical information.

ANATOMICAL GIFT

☐ Check this box if you also want the final document is to be treated as an Anatomical Gift. There are blanks at the end of the form that allow you to get specific about this subject.

Please note: We need to receive this questionnaire back from you at least 3 business days prior to your scheduled signing session.

PART 1: PRINCIPAL AND HEALTH CARE AGENT

My Personal Information

Name	
Street Address	
City/State/Zip	
Home No.	
Work No.	
Cell No.	
Date of Birth	
Soc Sec No.	

My First Choice for Health Care Agent

Name	
Street Address	
City/State/Zip	
Home No.	
Work No.	
Cell No.	
Relationship	

If you name two or more Agents as your first choice, please check one of the following

☐ My named Health Care Agents may act independently of one another. **OR**

☐ My named Health Care Agents must act jointly in agreement.

If my first choice for Health Care Agent is "not reasonably available to serve" as defined below, then I choose the following persons, in the following order, to serve as alternates or successors. "Not reasonably available to serve" shall mean that such person or persons (if more than one person is appointed at a time), is (1) not able to be contacted, or (2) not willing or able to act, (3) in a timely manner, considering the urgency of my health care needs. If a person named as a higher priority health care agent nominee is not reasonably available to serve at the time of need, temporarily my health care providers may rely on the next available and willing Health Care Agent nominee in priority until such time as the Health Care Agent nominee with a higher priority becomes reasonably available to serve.

My Second Choice for Health Care Agent

Name	
Street Address	
City/State/Zip	
Home No.	
Work No.	
Cell No.	
Relationship	

If you name two or more Agents as your 2nd choice, please check one of the following

☐ My named Health Care Agents may act independently of one another. **OR**

☐ My named Health Care Agents must act jointly in agreement.

My Third Choice for Health Care Agent

Name	
Street Address	
City/State/Zip	
Home No.	
Work No.	
Cell No.	
Relationship	

If you name two or more Agents as your 3rd choice, please check one of the following

☐ My named Health Care Agents may act independently of one another. **OR**

☐ My named Health Care Agents must act jointly in agreement.

PART 2: HEALTH CARE POWERS AND DUTIES

- My Health Care Agent can only make decisions for me if I lack decision-making capacity, as determined by my physician, or if I am unable to communicate decisions for myself.

- My Health Care Agent has authority hereunder to remove any treating physician, attending physician, or my personal physician, to the extent I would as a patient, but also regarding the issue of determining whether or not I lack decision-making capacity and may obtain one, and only one, second opinion in that regard.

- My Health Care Agent can only make decisions in agreement with instructions I make in this document.

- My Health Care Agent can make decisions based on what he or she knows about my wishes, unless I have given specific directions in this document.

- My Health Care Agent must act in my best interests if specific instructions are not available in this document.

I also authorize my Health Care Agent to:

☐ Consent to, refuse, or withdraw any health care, treatment, service or procedure.

☐ Choose my health care providers.

☐ Choose where I live when I need health care and what personal security measures are needed to keep me safe.

☐ Read or obtain copies of my medical records.

☐ Provide information about my medical records to others.

☐ Carry out my wishes regarding a funeral, burial or what will happen to my body when I die.

☐ Make decisions about mental health treatment including electroconvulsive therapy and anti-psychotic medication, including neuroleptics.

☐ In the event that I am pregnant, determine whether to attempt to continue my pregnancy to deliver based on my health care agent's understanding of my values.

☐ Continue as my health care agent even if a dissolution, annulment or termination of our marriage is in process or has been completed.

Limiting Powers of My Health Care Agent

❖ I wish to limit the powers of my health care agent in the following way(s):

_____

or circle NONE

PART 3: HEALTH CARE DIRECTIVES

I do want to have all of the following appropriate health care, if I am diagnosed with a terminal condition <u>and</u> become unable to communicate or participate in decisions regarding my health care:

☐ I do want medication and medical procedures to provide comfort, care and to alleviate pain.

☐ I do want whatever care is appropriate to keep me as comfortable and free of pain as reasonably possible, including administration of pain relieving drugs and surgical procedures calculated to relieve my pain and suffering, even though some drugs may hasten the moment of my death.

☐ I do want a "terminal condition" to be diagnosed by two (2) physicians.

☐ Certain procedures could be tried for a limited time to determine if my condition improves.

- ☐ My Health Care Agent shall determine what a "limited time" is.
- ☐ My "attending physician" shall determine what a "limited time" is.
- ☐ My "Health Care Agent and attending physician" shall determine what a "limited time" is.

☐ My Health Care Agent shall make all other decisions.

I particularly DO NOT want the following treatments if I am diagnosed with a terminal condition and become unable to communicate or participate in decisions regarding my health care:

☐ I do not want to be kept alive by medical procedures or medications if I am terminally ill and there is no reasonable hope of my recovery, and where the application of life sustaining procedures would only serve to artificially prolong the dying process.

☐ I do not want to be over sedated. I am willing to bear some pain if it allows me the ability to communicate with my family and friends.

☐ I do not want electrical, mechanical or chemical resuscitation of my heart.

☐ I do not want nasogastric tube feeding when I am no longer able to swallow.

☐ I do not want kidney dialysis when kidneys fail to function.

☐ I do not want surgery or other invasive procedures.

☐ I do not want chemotherapy.

☐ I do not want radiation therapy.

☐ I do not want transfusion of blood or blood products.

☐ Except as provided above, my agent shall make all other decisions.

My Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people think about medical treatments, what quality of life means to them and how they wish to be treated when dying or after they have passed away.

❖ My decision makers should know the following about how my religious or spiritual beliefs regarding my health care:

❖ My religion or spirituality is:

❖ My congregation or spiritual community is:

❖ I wish to have my spiritual leader consulted: ☐ Yes ☐ No

My Preferences for Care when Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive the following:

☐ I wish to live my last days:

- ☐ At home if doing so does not impose undue burden on my family.
- ☐ At a hospital.
- ☐ At a nursing home.
- ☐ Through Hospice care.
- ☐ Other health care providers:
- ☐ My Health Care Agent shall make all other decisions.

Other wishes I wish to state about my care when I am dying: _____
_____
_____
or circle NONE

My Preferences About My Body When I Die

☐ I request cremation. Arrangements have been made at:

☐ I request burial. Arrangements have been made at:

☐ My agent shall make all other decisions.

My Wishes About Organ Donation

☐ I DO wish to donate organs, tissues or other body parts when I die.

☐ I wish to only donate the following:

☐ I have agreed in another document or form to donate some or all of my organs, tissues or other body parts when I die.

☐ I DO NOT wish to donate organs, tissues or other body parts when I die.

☐ I am attaching additional instructions concerning my health care goals, values, and preferences.

If you want to include attachments on your final document, please e-mail them to us as Microsoft Word, WordPerfect or text document or, if you do not have access to e-mail, send copies to us when you return this questionnaire to our offices. Note: We will not review nor do we give opinions with regard the appropriateness or consistency of your attachments with the rest of this document. They will be attached unread to your final document.

This document has been completed _____ this day of _____, 20____.

Signed by: _____

When the worksheet has been completed please sign it and date it, return it to our office:

by mail:

LEHNER LAW OFFICE, LLC
1069 S. Robert St., Ste 100
West St. Paul, MN 55118

or E-mail:

andy@lehnerlawoffice.com

or Fax:

651.222.1122

If you have questions contact our office at 651.222.9829
Thank you

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