Honoring Choices MINNESOTA

Dardaaranka Daryeel Caafimaad

Doorashooyinka oo la Ixtiraamo Minnesota

Waxa uu ka soo baxayaa shuruudaha Deganeyaasha Minnesota iyo Wisconsin

Dardaarankayga Daryeel Caafimaad

Waxa aan sameeyay dukumentigan aniga oo wax badan ka fiirsaday si aan u sheego doorashooyinka daweynta iyo rabitaankayga shakhsi haddii aanan rabitaankayga gudbin karin ama aanan naftayda u gaadhi karin go'aamo daryeel caafimaad. Waxa kale oo aan magacaabay wakiil daryeel caafimaad oo ii hadla. Wakiilkaygu waxa uu awoodaa inuu go'aamo caafimaad ii gaadho, oo ay ku jirto go'aanka inuu diido daweynada aanan rabin. Dukumenti kasta oo kan ka hor la sameeyay sharci ma aha ama waxba kama jiraan.

Magacayga: _____

Taariikhdayda dhalasho: _____

Adreeskayga: _____

Lambarkayga teleefonka: _____

Lambarkayga teleefonka gacanta ama moobilka: _____

Qaybta 1: Wakiilkayga Daryeel Caafimaad

Haddii aanan awoodin inaan sheego ama soo gudbiyo rabitaanadayda iyo go'aamadayda daryeel caafimaad sababta oo ah cudur ama dhaawac, ama haddii dhakhaatiirtayda ama bixiyeyaashayda daryeel caafimaad go'aamiyaan in aanan awoodin inaan naftayda u gaadho go'aamo daryeel caafimaad,* waxa aan qofka ama dadka soo socda u magacaabay inuu wakiil iiga ahaado rabitaankayga oo ii gaadho go'aamo daryeel caafimaad, oo uu ku jiro go'aanka inuu diido daweynada aanan rabin. Markii aan dooranayay wakiil daryeel caafimaad, waxa aan ka fiirsaday awoodda uu qofkani u leeyahay inuu isaga oo raali ka ah uu gaadho go'aamo isaga oo ka warqaba doorashooyinkayga xagga daweynta. Qofkani waa qof raaci karaa rabitaanadayda wakhtiyada ay jirto xasilooni-dari.

Wakiilkayga daryeel caafimaad ee koobaad waa:

Magac: _____

Waxa aanu isu nahay:_____

Teleefon (h) _____ Teleefon (c) _____

Teleefon (w) _____

Adrees: _____

- *Waxa aan fahamsan ahay in wakiilkaygu aanuu noqon karin dhakhtar ama bixiye daryeel caafimaad ama shaqaale ka tirsan bixiye daryeel caafimaad oo toos ii siiya daryeel ama siiya qof aanu is qabno, haddii qofkaas ah bixiye daryeel ee aan wakiilanayo aanuu naga dhexeynin xidhiidh dhiig ama guur, xidhiidh ah wehel ahaansho hoy oo diiwaansan, ama xidhiidh korsasho. Haddii wakiilkaygu yahay bixiye daryeel caafimaad ama shaqaale ka tirsan bixiye daryeel caafimaad, sababta aan qofkaas u doortay waa tan:*

_____
_____.

Haddii aan joojiyo awoodda wakiilkayga koowaad ama haddii wakiilkayga koowaad aanuu raali ka ahayn, awoodin, ama loo heli karin si caqli-gal ah si uu iigu gaadho daryeel caafimaad, waxa aan wakiilkayga beddelka ah u magacaabay:

<u>Wakiilka beddelka ah ee daryeelka caafimaadka:</u>

Magac: _____

Waxa aanu isu nahay: _____

Lambarada Teleefon (h) _____ Teleefon (c) _____

Teleefon (w) _____

Adrees: _____

Awoodaha wakiilkayga daryeel caafimaad:

Wakiilkayga daryeel caafimaad waxa uu si toos ah u leeyahay dhamaan awoodaha soo socda marka aanan awoodin inaan naftayda u hadlo:

A. Inuu sameeyo doorashooyin ku saabsan daryeelka caafimaadkayga. Waxan tan ku jira waxyaabaha ah: in la iga saaro ama aan la i galin tuubooyin quudin, baadhitaanno, dawooyin, qalitaano iyo go'aamo daweyn haddii aan uur leeyahay iyo dhamaan noocyada daweynta caafimaadka maskaxda, oo ay ku jiraan daweynada caafimaadka maskaxda ee leh daakhilaad ama dawooyin. Haddii daweyntu tahay mid bilaabantay, wakiilkaygu waa uu sii wadi karaa ama joojin karaa iyada oo ku saleysan fariimahayga.
B. Waxa uu fasiri karaa fariin kasta oo aan ku bixiyay foomkan isaga oo raacaya waxa uu ka fahmay rabitaanadayda, waxa aan qiimeeyo iyo waxa aan rumeysan ahay
C. Waxa uu fiirin karaa oo bixin karaa diiwaanadayda caafimaadka iyo faylashayda shakhsi ahaaneed taasoo ku xidhan daryeelka caafimaadkayga
D. Waxa uu diyaarin karaa daryeelka caafimaadkayga iyo daweyntayda oo ah gudaha Minnesota ama gobolka kale oo kasta ama goobta uu u maleeyo inay haboon tahay. Waxa tan ku jira guryaha daryeelista iyo goobaha deganaanta ee ku saleysan beesha.
E. Waxa uu go'aan ka gaadhi karaa kuwa ay noqon doonaan bixiyeyaasha daryeel caafimaad iyo hay'adaha i siin doona daweyn caafimaad

Faalooyin ama xadeyn ku saabsan qodobada sare (tusaale ahaan, dadka aad rabtid ama aanad rabin inay lug ku yeeshaan gaadhista go'aamo ay wakiil kaaga yihiin ama xadeyn ku saabsan awoodaha sare ee wakiilkaaga):

Awoodo dheeraad ah oo uu leeyahay wakiilkayga daryeel caafimaad: (Haddii aan rabo in wakiilkaygu yeesho mid ka mid ah awoodahan soo socda, waxa aan calaamad saari doonaa sanduuqa ku yaala xagga hore ee hadal kasta oo hoos ku yaala.)

- Inuu diyaariyo oo go'aamo ka gaadho daryeelka jidhkayga ka dib dhimasho
- Inuu sii ahaado wakiilkayga daryeel caafimaad xiitaa haddii hawlgal ah fasiqid, baabi'in ama joojin lagu hayo guurkayaga ama wehelnimada guriga ama la soo dhameeyay hawlgalkaas
- Markii aan sidaas u wakiisho, inuu ii sameeyo go'aamo daryeel caafimaad xiitaa haddii aan awoodo inaan naftayda go'aan u gaadho ama u hadlo.

Boggan waxa laga rabaa kaliya deganeyaasha Wisconsin.

Dukumentiga Awoodda Wakiilnimo ee Daryeel Caafimaad

Ogeysiis ku Socda Qofka Sameynaya Dukumentigan: Waxa aad xaq u leedahay inaad gaadhid go'aamo ku saabsan daryeelka caafimaadkaaga. Lagama yaabo in lagu siiyo daryeel caafimaad haddii aad diidan tahay, isla markaana waxa dhici karta in daryeelka caafimaad ee lagama-maarmaanka ah aan la joojin ama la hakin haddii aad diidid.

Sababta oo ah bixiyeyaashaada daryeel caafimaad oo marrarka qaarkood ay dhici karto in aanay fursad u helin inay kula yeeshaan xidhiidh mudo dheer, badanaa lama socdaan waxa aad rumeysan tahay iyo waxa qiimaha kula leh iyo faahfaahinta xidhiidhkaaga qoys ahaaneed. Taasi waxay dhib keenaysa haddii jidh ahaan ama maskax ahaan aanad awoodin inaad gaadhid go'aamo ku saabsan daryeelka caafimaadkaaga.

Si looga baxsado dhibaatadaas, waxa lagaa rabi karaa inaad saxeexdid dukumentigan sharciga ah si aad u cadeysid qofka aad rabtid inuu kuu gaadho go'aamo daryeel caafimaad haddii aanad awoodin in adigu aad gaadhid go'aamadaas. Qofkaas waxa loo yaqaanaa wakiilkaaga daryeel caafimaad. Waa inaad xoogaa wakhti ah isa siisid oo aad fikradahaaga iyo waxa aad rumeysan tahay ee ku saabsan daweynta caafimaadka aad kala hadashid qofka ama dadka aad sheegtay. Waxa aad dukumentigan ku sheegi kartaa nooc kasta oo ah daryeel caafimaad oo aad rabtid ama aanad rabin, waxana aad xadeyn kartaa awoodda wakiilkaaga daryeel caafimaad. Haddii wakiilkaaga daryeel caafimaad aanuu ka warqabin rabitaanadaada ku saabsan go'aamo daryeel caafimaad oo gaar ah, waxa laga rabaa inuu go'aamiyo waxa danta ugu fiicani kuugu jirto marka uu gaadhayo go'aanka.

Kani waa dukumenti sharci ah oo muhiim ah. Waxa uu wakiilkaaga siinayaa awood balaadhan oo uu kuugu gaadho go'aamo daryeel caafimaad. Waxa uu laalayaa ama burinayaa awood wakiilnimo daryeel caafimaad kasta oo aad hore u bixisay. Haddii aad rabtid inaad beddeshid Awoodda Wakiilnimo Daryeel Caafimaad, waxa aad dib uga noqon kartaa dukumentigan wakhti kasta marka aad burburisid, ama adiga oo qof kale fara ama u sheegaa inuu hortaada ku burburiyo, ama marka aad saxeexdid ee aad taariikheysid hadal burin, ama marka aad laba markhaati hortooda ka sheegtid inaad dib uga noqotay.

Haddii aad dib uga noqotid, waa inaad ogeysiis siisid wakiilkaaga, bixiyeyaashaada daryeel caafimaad iyo qof kale kasta oo aad siisay koobi. Haddii wakiilkaagu yahay qof aad is qabtaan oo guurkaaga la baabi'iyo ama aad is furteen ka dib saxeexidda dukumentigan, magacaabista ah in qof aad is qabteen yahay wakiilkaaga daryeel caafimaad waxa uu noqonayaa mid aanay waxba ka jirin.

Waxa kale oo aad dukumentigan u isticmaali kartaa inaad sameysid ama diidid deeq xubin jidh ka dib geeridaada. Haddii aad dukumentigan u isticmaashid inaad sameysid ama diidid deeq xubin jidh, dukumentigan waxa uu burinayaa diiwaan ama qoraal kasta oo hore oo ku saabsan deeq xubin jidh oo aad sameysay. Waxa aad dib uga noqon kartaa ama wax ka beddeli kartaa deeq xubin jidh oo kasta oo aad ku sameysid dukumentigan adiga oo xariiq marinaya qodobada ku saabsan deeq xubin jidh ee ku qoran dukumentigan.

Ha saxeexin dukumentigan adiga oo si cad u fahma mooyaane.

Waxa lagugula talinayaa in asalka dukumentigan uu kuu hayo dhakhtarkaagu.

Qaybta 2: Dardaarankayga Daryeel Caafimaad

Doorashooyinkayga iyo rabitaanadayda daryeelka caafimaadkayga waa sidan soo socota. Waxa aan wakiilkayga weydiisanayaa inuu wakiil ka noqdo, waxana aan dhakhaatiirtayda (iyo/ama kooxda daryeelka caafimaadka) weydiisanayaa inay ixtiraamaan, haddii ay dhacdo in aanan awoodin isgaadhsiin ama aanan awoodin inaan naftayda u hadlo. **Waxa aan calaamadeeyay sanduuqa hoose ee ku aadan ikhtiyaarka aan u doortay xaalad kasta**.

Fiiro: U ma baahnid inaad bixisid fariimo qoran oo ku saabsan daweynada ama la-tacaalista lagu dheereynayo nolosha , laakiin haddii aad sameysid waxa laga helaa gargaar. Haddii aad dooratid in aanad sameynin, waxa uu wakiilkaaga daryeelka caafimaadka sameyn doonaa go'aamo ku saleysan fariimahaaga hadal ama afka ah ama waxa uu ka soo qaado inay danta ugu fiicani kuugu jirto.

1. Daweynada lagu dheereynayo noloshayda

Haddii aan gaadho xaalad ah in aanan awoodin inaan naftayda u gaadho go'aamo isla markaana ay si caqli-gal ah u sugan tahay in aanay ii soo noqon doonin awood aan ku garto qofka aan ahay (Deganeyaasha Wisconsin, haddii aan qabo xaalad geeri suge ah ama aan ku jiro xaalad miyir la'aan oo joogto ah):

◎ Waxa aan rabaa inaan **joojiyo ama la hakiyo dhamaan daweynada** sii dheereynaya noloshayda. Waxa tan ku jira balse kuma koobna quudinta tuubada loo isticmaalo, dheecaanada faleebo ahaan (IV) loo bixiyo, mishiinka neefsashada, dib-u-dhaqaajinta wadnaha iyo sambabka (CPR), iyo antibiyootikada.

ama

◎ **Waxa aan rabaa** dhamaan daweynada ama la-tacaalista haboon ee uu ku taliyo dhakhtarkaygu, ilaa dhakhtarkayga iyo wakiilkaygu ku heshiinayaan in daweynadaasi yihiin kuwo waxyeelo leh ama hadda ka dib aanay ahayn kuwo leh gargaar ama faa'iido.

Faalooyin ama fariimo loo sheegayo bixiyeyaasha daryeel caafimaad: _____

_____

_____

_____

_____.

Mid kasta oo aan ka doorto labadaas doorasho, waxa aan fahmay inay ii socon doonto siinta daweynta xanuunka iyo wixii nafisaad leh, iyo waliba cunto iyo hooreyaal afka laga qaato haddii aan awoodo inaan wax liqo.

2. Dib-u-dhaqaajinta Wadnaha iyo Sambabka (CPR)

Dib-u-dhaqaajinta Wadnaha iyo Sambabka (CPR) waa la-tacaalis la isticmaalo si la isugu dayo in la soo celiyo dhaqdhaqaaqa wadnaha iyo/ama neefsashada marka ay joogsadaan. Waxa ku jiri kara cadaadin laabta ah (laabta oo xoog loo riixo si wadnuhu u sameeyo isku ururid), dawooyin, shoog koronto (electrical shocks), iyo tuubo neefsasho.Waxan fahamsan ahay in dib-u-dhaqaajinta wadnaha iyo sambabka ay badbaadin karto nafta qof. Waxa kale oo aan fahamsan ahay in aanay si fiican ugu shaqeyn dadka qaba cuduro soo jiray mudo dheer iyo/ama dadka leh shaqeyn jidh oo dhibaateysan ee aan is daryeeli karin. Waxa aan fahamsan ahay in ka-soo-fiicnaanta saameynta dib-u-dhiqaajinta wadnaha iyo sambabka ay noqon karto mid leh xanuun iyo dhib. Sidaa daraadeed:

◎ **Ma rabo in dib-u-dhaqaajinta wadnaha iyo sambabka** la igu dayo haddii wadnahaygu joogsado ama neefsashadaydu joogsato, laakiin beddelkeeda, waxan rabaa in la oggalaado geeri dabiici ah.

ama

◎ **Waxa aan rabaa in la igu dayo dib-u-dhaqaajinta wadnaha iyo sambabka haddii** dhakhtarkaygu aanu go'aamin *mid* ka mid ah kuwan:

- Waxa aan qabaa cudur ama dhaawac aan laga bogsan karin waana aan dhimanayaa. ama
- Ma lihi suurtogal noolaansho oo caqli-gal ah haddii wadnahaygu joogsado ama neefsashadaydu joogsato. ama
- Waxa yar suurtogalka inaan sii noolaado mudo dheer haddii wadnahaygu joogsado ama neefsashadaydu joogsato isla markaana hawlgalka dib-u-dhaqaajinta wadnaha iyo sambabka waxa uu keeni doonaa xanuun ama waxyeelo laxaad leh.

ama

◎ **Waxa aan rabaa in dib-u-dhaqaajinta wadnaha iyo sambabka la igu dayo haddii wadnahayga ama neefsashadaydu joogsato.**

3. Doorashada Daweynta ama La-tacaalista

◎ Waxa aan halkan soo raaciyay ikhtiyaaradayda daweynta ee ku saabsan xaaladayda ama xaaladahayga caafimaad ee gaarka ah. Hadaladani waxay sheegayaan doorashooyinkayga daweynta. Nooc daweyn kasta oo aan doorto, waxa aan fahamsan ahay inay ii socon doonto siinta dawooyinka xanuunka iyo nafisaad helidda, iyo waliba cunto iyo hooreyaal afka la iga siiyo haddii aan awoodo inaan wax liqo.

Qaybta 3: Rajooyinkayga iyo Rabitaanadayda (Ikhtiyaar)

Waxan rabaa in ehelkayga iyo dadka i jecel ogaadaan fikradahan iyo dareenadan soo socda:

1. Waxyaabaha nolosha iiga dhiga mid u qalanta inaan sii noolaado waa:

2. Waxa aan rumeysan ahay in aan noloshu istaahilin mid sii jirta marka ay jiraan waxyaabahan:

3. Dooroshooyinkayga ku saabsan daweyn ama la-tacaalis gaar ah, haddii ay jiraan (waxa tan ku jiri kara rabitaanadaada ku saabsan mishiinada neefsashada, sifeynta kaadida (dialysis), antibiyootiko, quudinta tuubo la isticmaalayo, iwm.):

4. Fikradahayga iyo dareenadayda ku saabsan sida aan rabo inaan u dhinto iyo goobta aan rabo inaan ku dhinto waa:

5. Haddii aan dhimasho ama geeri ku dhowaado, waxan aan rabaa in dadka i jecel oggaadaan inaan jecelahay in la ii qabto waxyaabahan ah nafisaad ama xanuun-yareyn iyo taageero (hawlgalo cibaadaysi, tukasho, muusig, iwm.):

6. Diintaydu waa:

Waxan ahay _____ diin ahaan, waxana aan xubin ka ahay _____ oo ah beel ama jimciyad diineed (magaalo) _____. Fadlan isku day inaad ogeysiisid geeridayda oo aad abaabushid si ay u qabtaan tacsidayda/xuskayga/aasidayda. Waxan jecelahay, hadday suurtogal tahay, in tacsidayda ay ku jiraan kuwan (dad, muusig, hawlgalo cibaadaysi, iwm.):

7. Deeqid xubin jidhayga ah (waxba ha ku qoran haddii aanad wax doorasho ah sameynaynin):

_____ **Waxan rabaa inaan deeq u bixiyo** indhahayga, unugyo iyo/ama xubnaha jidhkayga, haddii ay suurtogal tahay. Rabitaanadayda gaarka ah waa (hadday jiraan):

_____ **Ma rabo inaan deeq u bixiyo** indhahayga, unugyo iyo/ama xubno jidh.

8. Rabitaano/fariimo kale:

Qaybta 4: Awood Sharci

Marka la fiiriyo sharciga Minnesota, waa inaad dukumentigan ku hor saxeexdid oo ku hor taariikheysid laba markhaati ama nootaayo dadweyne (notary public). **Deganeyaasha Wisconsin waa inay dukumentigan ku hor saxeexaan oo ku hor taariikheeyaan laba markhaati. (Gudaha Wisconsin, Shaqaalaha Bulshada iyo wadaadada ayaa kaligood ah bixiyeyaasha daryeel caafimaad ee noqon kara markhaati.)**

Aniga oo xor ah ayaan sameeyay dukumentigan; waxan u fikirayaa si cad, waxana uu dukumentigani sheegayaa rabitaanadayda ku saabsan go'aamadayda daryeel caafimaad ee mustaqbalka:

Saxeex: _____ Taariikh:_____

Haddii aanan saxeexi karin magacayga, waxa aan weydiisanayaa qofka soo socda inuu ii saxeexo:

_____

Saxeexa (qofka la weydiisto inuu saxeexo):_____ Taariikh:_____

Cadeynta Markhaatiyada: Aniga ayaa shakhsiyan shaahid ka ahaa ama arkayay saxeexidda dukumentigan. Waxa aan cadeynayaa in dukumentigani aanuu ii magacaabin inaan noqdo wakiil daryeel caafimaad.

Haddii aan ahay bixiye daryeel caafimaad ama shaqaale ka tirsan bixiye daryeel caafimaad oo daryeel toos ah siinaya qofka kor ku qoran, waa inaan xariiqdan ku qoraa xuruufta ugu horeysa saddexdayda magac ama magacyadayda (initials): _____. Waa in ugu yaraan hal markhaati aanuu ahayn daryeel bixiye ama shaqaale ka tirsan daryeel bixiye oo daryeel toos ah bixinaya maalinta dukumentigan la saxeexo. **Markhaatiyada Wisconsin qofka kor ku qoran lama lahaan karaan xidhiidh ah dhiig, guur, korsasho ama wehelnimo qoys, maalka qofka kuma lahaan karaan sheegasho ama si toos ah dhaqaale ahaan mas'uul uguma noqon karaan daryeelkooda.**

Markhaatiga Koobaad:

Saxeex:_____ Taariikh:_____

Magaca oo ah xuruuf kala go'an _____

Adrees _____

Markhaatiga Labaad:

Saxeex:_____ Taariikh:_____

Magaca oo ah xuruuf kala go'an _____

Adrees _____

<u>Nootaayo Dadweyne</u>:

Aniga hortayda _____ (taariikh), _____ (magac) waxa uu qiray saxeexiisa ama saxeexeeda ku qoran dukumentigan ama waxa uu qiray inuu awood u siisay ama u siisay qofka saxeexaya dukumentigan inuu wakiil ahaan ugu saxeexo. Ma ahi qof dukumentigani u magacaabayo wakiil daryeel caafimaad.

Saxeexa nootaayada: _____

Shaambadda Nootaayada:

Qaybta 5: Talaabooyinka Xiga

Imminka mar haddii aad buuxisay dardaarankaaga daryeel caafimaad, waa inaad sidoo kale qaadid talaabooyinka soo socda.

- U sheeg qofka aad u magacawday inuu kuu noqdo wakiil daryeel caafimaad, haddii aanad taa hore u sameynin. U hubso in qofkaasi awoodo inuu mustaqbalka kuu qaban karo shaqadan muhiimka ah.
- Koobi ah dardaarankaaga daryeelka caafimaadka sii wakiilkaaga daryeel caafimaad.
- La hadal qoyskaaga intiisa kale iyo saaxiibada kuu dhow ee laga yaabo inay arrimahaaga lug ku yeeshaan haddii aad qabtid cudur ama dhaawac culus. U hubso inay yaqaanaan qofka uu yahay wakiilkaaga daryeel caafimaad, iyo waxa ay yihiin rabitaanadaadu.
- Dhakhtarkaaga sii koobi ah dardaarankaaga daryeel caafimaad. U hubso in la fahmo rabitaanadaada oo la raaci doono.
- Koobi ah dardaarankaaga daryeel caafimaad ku hayso meel si fudud looga heli karo.
- Haddii aad tagtid cisbitaal ama hoy daryeel, sii qaado koobi ah dardaarankaaga daryeel caafimaad oo weydiiso in lagu daro diiwaankaaga ama faylkaaga caafimaadka.
- Dib u fiiri rabitaanadaada daryeel caafimaad wakhti kasta oo laguu sameeyo baadhis jidh ama markasta oo mid kasta oo ah kuwan dhacaan:
    - Toban sanno oo cusub – marka toban sanno oo cusub u bilaabmaan noloshaada.
    - Geeri – markasta oo dhimasho ama geeri ku dhacdo qof gacalkaaga ah ama aad jeceshay.
    - Furitaan – marka uu kugu dhaco furitaan ama isbeddel qoys oo weyn oo kale.
    - Cilad-sheegid – marka lagugu sheego xaalad caafimaad oo culus.
    - Hoos-u-dhac – marka xaalad caafimaad oo aad qabtay si weyn u sii xumaato ama ka sii darto, gaar ahaan marka aanad awoodin inaad kaligaa noolaatid.

Koobiyo ah dukumentigan waxa la siiyay:

Wakiilka Daryeel Caafimaad ee Koobaad – Magac: _____

Teleefon: _____ Teleefon Gacan/Moobil: _____

Wakiilka Daryeel Caafimaad ee Beddelka ah – Magac: _____

Teleefon: _____ Teleefon Gacan/Moobil: _____

Bixiye Daryeel Caafimaad/Xarun:

Magac: _____ Teleefon: _____

Magac: _____ Teleefon: _____

Magac: _____ Teleefon: _____

Haddii rabitaanadaadu is beddelaan, buuxi foom dardaaran daryeel caafimaad oo cusub oo u sheeg wakiilkaaga, qoyskaaga, dhakhtarkaaga, iyo qof kasta oo koobi ka haysta waraaqihii hore ee dardaarankaaga daryeel caafimaad.

Honoring Choices® MINNESOTA

Health Care Directive

Meets legal requirements for Minnesota and Wisconsin residents

Introduction

I have created this document with much thought to give my treatment choices and personal preferences if I cannot communicate my wishes or make my own health care decisions. I have also appointed a health care agent to speak for me. My agent is able to make medical decisions for me, including the decision to decline treatments that I do not want. Any document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

_____

My telephone number: _____

My cell:_____

Part 1: My Health Care Agent

If I am unable to communicate my wishes and health care decisions due to illness or injury, or if my health care providers have determined that I am not able to make my own health care decisions, I appoint the following person(s) to represent my wishes and make my health care decisions*, including the decision to decline treatments I do not want. When choosing a health care agent I have considered his/her ability to willingly make decisions while being aware of my treatment choices. This person can follow my wishes under times of stress.

Name: _____ *Date:* _____

My primary (main) health care agent is:

Name: _____

Relationship: _____

Telephone numbers:

(H) _____

(Cell) _____

(W) _____

Address: _____

_____

* *I understand that my agent cannot be a health care provider or employee of a health care provider giving direct care to me or their spouse, unless I am related to that person by blood or marriage, registered domestic partnership, or adoption. If my agent is a health care provider or an employee of a health care provider, my reason for choosing him or her is:* _____

_____

_____

_____

_____

_____

If I cancel my primary agent's authority or if my primary agent is not willing, able, or reasonably available to make a health care decision for me, I name as my alternate agent:

Alternate health care agent:

Name: _____

Relationship: _____

Telephone numbers:

(H) _____

(Cell) _____

(W) _____

Address: _____

_____

Powers of my health care agent

My health care agent automatically has all the following powers when I am unable to speak for myself:

☐ Make choices for me about my medical care. This includes taking out or not putting in tube feedings, tests, medicine, surgery and decisions of treatments if I am pregnant and all types of mental health treatment, including intrusive mental health treatments or medications. If treatment has already begun, my agent can continue it or stop it based on my instructions.

☐ Interpret any instruction I have given in this form according to his or her understanding of my wishes, values and beliefs.

☐ Review and release my medical records and personal files as needed for my medical care.

☐ Arrange for my medical care and treatment in Minnesota or any other state or location he or she thinks is appropriate. This includes nursing homes and community-based residential facilities.

☐ Decide which health providers and organizations provide my medical treatment.

Comments or restrictions on the above (e.g., persons you would or would not want to be involved in making decisions on your behalf or limitations on the above powers for your agent): _____

_____

_____

_____

_____

_____

Additional powers of my health care agent: *(If I <u>want</u> my agent to have any of the following powers, I will check the box in front of each statement below)*

☐ Arrange for and make decisions about the care of my body after death.

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

☐ When I so delegate, make health care decisions for me even if I am able to decide or speak for myself.

Name: _____ *Date:* _____

This page is required for Wisconsin residents only.

Power of Attorney for Healthcare Document

Notice to the Person Making This Document:

You have the right to make decisions about your healthcare. No healthcare may be given to you over your objection, and necessary healthcare may not be stopped or withheld if you object.

Because your healthcare providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your healthcare.

In order to avoid this problem, you may sign this legal document to specify a person who you would want to make healthcare decisions for you if you become unable to make those decisions personally. That person is known as your healthcare agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons you might specify. You may state in this document any types of healthcare that you do or do not desire, and you may limit the authority of your healthcare agent. If your healthcare agent is unaware of your desires with respect to a particular healthcare decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make healthcare decisions for you. It revokes any prior power of attorney for healthcare that you may have made. If you wish to change your Power of Attorney for Healthcare, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses.

If you revoke, you should notify your agent, your healthcare providers and any other person to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced after signing this document, the designation of your spouse as healthcare agent shall no longer be valid.

You may also use this document to make or refuse to make any anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift you may have made. You may revoke or change any anatomical gift that you make in this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it.

It is suggested that you keep the original of this document on file with your physician.

This page is required for Wisconsin residents only.

Name: _____ *Date:* _____

Part 2: My Health Care Instructions

My choices and preferences for my health care are as follows. I ask my agent to represent them, and my doctors (and/or health care team) to honor them, should I become unable to make my own health care decisions or communicate my wishes. ***I have checked the box below for the option I prefer for each circumstance.***

Note: You do not need to provide written instructions about treatments to extend your life, but it is helpful to do so. If you choose not to, your health care agent will make decisions based on your spoken directions or on what is considered to be in your best interest.

1. Treatments to prolong my life:

If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to know who I am (For Wisconsin residents, if I have a terminal condition or am in a persistent vegetative state):

☐ I want to **stop or withhold all treatments** that are prolonging my life. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics.

or

☐ **I *do* want** all appropriate treatments recommended by my doctor, until my doctor and agent agree that such treatments are harmful or no longer helpful.

Comments or directions to health care providers:

_____
_____
_____
_____
_____

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

Name: _____ *Date:* _____

2. **Cardiopulmonary resuscitation. CPR** is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube. I understand that CPR can save a life. I also understand that it does not work as well for people who have chronic (long-term) diseases and/or impaired functioning. I understand that recovery from CPR can be painful and difficult. Therefore:

   ☐ I do not want CPR attempted if my heart or breathing stops, but rather, want to permit a natural death.

   or

   ☐ I want CPR attempted unless my doctor determines any of the following:
   - I have an incurable illness or injury and am dying; or
   - I have no reasonable chance of survival if my heart or breathing stops, or
   - I have little chance of long-term survival if my heart or breathing stops and the process of resuscitation would cause significant suffering

   or

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

3. **Treatment Preferences.**

   ☐ I have attached treatment preferences for my specific health condition(s). These statements describe my treatment choices. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as foods and fluids by mouth if I am able to swallow.

Name: _____ *Date:* _____

Part 3: My Hopes and Wishes (Optional)

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

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

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

3. My choices about specific medical treatments, if any (this could include your wishes regarding ventilators, dialysis, antibiotics, tube feedings etc.):

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

Name: _____ *Date:* _____

5. 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.):

6. Religious affiliation

I am of the _____ faith, and am a member of _____ faith community in (city) _____. Please attempt to notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

7. **Organ donation** (leave blank if you have no preference).

☐ **I do want** to donate my eyes, tissues and/or organs, if able. My specific wishes (if any) are:

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

8. Other wishes/instructions:

Name: _____ *Date:* _____

Part 4: Legal Authority

Under Minnesota law, you must have this document signed and dated in the presence of two witnesses or a notary public. **Wisconsin residents must have this document signed and dated in front of two witnesses.** (**Social workers and chaplains are the only health care providers who can witness in Wisconsin.**)

I have made this document willingly, I am thinking clearly, and this document expresses 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): _____

Statement of Witnesses:

I personally witnessed the signing of this document, and I certify that I am not appointed as a health care agent in this document.

If I am a health care provider or an employee of a health care provider giving direct care to the person listed above, I must initial this line: _____.
At least one witness cannot be a provider or an employee of the provider giving direct care on the day this document is signed. **Wisconsin witnesses cannot be related to the person listed above by blood, marriage, adoption or domestic partnership, cannot have a claim on the person's estate or be directly financially responsible for their health care.**

Witness Number One:

Signature _____ Date _____

Print name _____

Address _____

Witness Number Two:

Signature _____ Date _____

Print name _____

Address _____

or

Notary Public:

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. I am not named as a health care agent in this document.

Signature of notary: _____

Notary stamp:

Part 5: Next Steps

Now that you have completed your health care directive, you should also take the following steps.

- Tell the person you named as your health care agent, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future.
- Give your health care agent a copy of your health care directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.
- Give a copy of your health care directive to your doctor. Make sure your wishes are understood and will be followed.
- Keep a copy of your health care directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a 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: _____

Cell: _____

Alternate Health Care Agent

Name: _____

Telephone: _____

Cell: _____

Health Care Provider/Clinic

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Name: _____

Telephone: _____

If your wishes change, fill out a new health care directive form and tell your agent, your family, your doctor, and everyone who has copies of your old health care directive forms.

Name: _____ *Date:* _____