My LIVING WILL
A Minnesota Health Care Directive

Identification: The following information will be used to identify you and your family, if you experience a health crisis and are unable to speak for yourself.

Name: _____ **Alias** (or Street Name): _____

Mailing address: _____

_____

Date of Birth (month/day/year): _____/_____/_____

Religion or Spirituality: _____

Marital Status: _____

Name and contact information of family members, friends, or agencies I would want notified if I were seriously ill or dying (please include phone numbers if you have them):

_____

_____

I **do not** want these people notified: _____

Things that would help emergency and health care staff to identify me: (describe)

Scars: _____

Tattoos/Piercing: _____

Birthmarks: _____

Other: _____

I receive health care at (list doctor, clinic, health plan or hospital):

_____

I (write name here)_____ understand that this document allows me to explain what I want for my health care if I cannot speak for myself and to name a person to make health care decisions for me.

Introduction: There are three sections to this living will.

- **Part One is for you to explain in a legal document what you would want for your health care in the event that you cannot speak for yourself.**
- **Part Two is for you to name a person you trust who could make health care decisions for you if you could not speak for yourself.**
- **Part Three will give you a chance to reflect upon your life and values; this part will help your family, friends, and health care professionals understand you better.**

You do not have to complete all three parts, and you do not have to answer every question. This living will can be a work in progress and changed at any time. To make this living will legal, you will need to sign it and have it notarized or witnessed by two people.

Part One: Health Care and After Death Care Instructions

This is what I would want for my medical treatment if I were seriously ill and there was a *good chance I would recover*.

☐ All life sustaining treatments (I want everything done to help me recover – for example CPR, a breathing machine, a feeding tube, all medications, surgery, blood transfusions, etc.)

☐ I would want everything done except the following: ☐ Feeding Tube ☐ Other_____

☐ I prefer to have this person decide for me: _____

☐ I would not want any life sustaining treatments

☐ Other: _____

This is what I would want if I were *dying* *(for example, if you had advanced cancer and could not make decisions for yourself)*.

☐ All life sustaining treatments

☐ I would want everything done except the following: ☐ Feeding Tube ☐ Other_____

☐ I prefer to have this person decide for me: _____

☐ I would not want any life sustaining treatments

☐ Other: _____

This is what I would want if I were *permanently unconscious* *(for example, if you were in an accident that left you in a permanent coma)*.

☐ All life sustaining treatments

☐ I would want everything done except the following: ☐ Feeding Tube ☐ Other_____

☐ I prefer to have this person decide for me: _____

☐ I would not want any life sustaining treatments

☐ Other: _____

This is what I would want if *others had to completely take care of me* *(for example, if you had a stroke and you were conscious but couldn't communicate, bathe yourself, feed yourself, or go to the bathroom on your own)*.

☐ All life sustaining treatments

☐ I would want everything done except the following: ☐ Feeding Tube ☐ Other

☐ I prefer to have this person decide for me: _____

☐ I would not want any life sustaining treatments

☐ Other: _____

These are my beliefs about when life would no longer be worth living.

_____

_____

This is how I feel about getting pain medication if I were seriously ill or dying.

☐ I want pain medication even if it makes me less alert or could shorten my life if I were dying
☐ I would rather be in pain than risk being less alert.
☐ I don't know, I would let others decide
Other: _____

This is where I would like to receive health care: _____

This is the doctor that I would like to provide my health care for me (if you have a preference):

_____

This is where I would like to die (at hospital, home, etc.):_____

These are other wishes or concerns I have about my care at the end of my life:

_____

These are my wishes about organ donation.

☐ I want to donate all my organs (including my eyes and skin)

☐ I want to donate all my organs except: _____

☐ I do not want to donate my organs

☐ Other: _____

These are my wishes about what happens to my body after I die.

☐ I want to be buried. This is where I want to be buried: _____

☐ I want to be cremated. This is where I want my ashes to be stored: _____

☐ These are other wishes I have about what happens to my body after I die: _____

_____

☐ **I want a memorial service. These are specific instructions I have for the service** (*for example who you want to conduct the service, where you want the service, any spiritual or religious traditions or songs you want included in the service*).

_____

_____

_____

☐ **I do not want a memorial service.**

_____**(Date/Initials)**

Part Two: Naming a Person to Make Health Care Decisions
(This person is my appointed health care agent)

This is the person I want to make health care decisions for me:

Name: _____

Relationship to me: _____

Address: _____

_____

Telephone: _____

This is another person I trust to make health care decisions for me:

(If the first person is not available)

Name:_____

Relationship to me: _____

Address: _____

_____

Telephone: _____

I give the person(s) named above the power to (please check all that apply):

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

☐ Stop or not start medical intervention that is keeping or might keep me alive.

☐ Choose my health care providers.

☐ Obtain copies of my medical records and allow others to see them.

☐ Choose where I live when I need health care and how to keep me safe.

☐ Decide whether or not to donate organs, tissues, and eyes, when I die.

☐ Decide what will happen with my body when I die.

These are other things I want the person I name to be able to do, or not do, for me.

_____

_____

These are the reasons I named a health care professional to make decisions for me.

(Fill this question out <u>only if you appointed your health care provider</u>).

_____

_____

_____**(Date/Initials)**

Part Three: Maintaining My Dignity

These are the things I am most proud of in my life: *(Think about your relationships and goals, what kind of person you are, and what you've accomplished in your life)*

_____

_____

_____

I would want to be remembered as a person who:

_____

_____

_____

People who care for me could do the following to respect my dignity at the end of my life:

_____

_____

_____

These are other values I have that are important to me for my health care at the end of my life:

_____

_____

_____

These are my goals for my health and health care when I am seriously ill or dying:

_____

_____

_____

These are my fears about my health and health care when I am seriously ill or dying:_____

_____

_____

_____

_____**(Date/Initials)**

These are my concerns about death:

_____

_____

_____

These are my concerns about a relationship I have:

_____

_____

_____

These are my concerns about how my health problems might affect others:

_____

_____

_____

Copies of this document will be given to:

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

Health Care Provider/Clinic:

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

MAKING THE DOCUMENT LEGAL

There are two ways to make this document legal (<u>choose one of them</u>)

1) Sign and Date below. Find two people to witness this document and sign below.

OR

2) Get this document signed by a notary public, who will watch you sign and date below.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My signature: _____

Date signed: _____

Date of birth: _____

Address: _____

If I cannot sign my name, I can ask someone to sign this document for me.
Signature of the person who I asked to sign this document for me:

_____

Printed name of the person who I asked to sign this document for me:

CHOOSE EITHER OPTION 1 OR OPTION 2

Option 1: Signatures of Two Witnesses – (Cannot be any person named in Part Two)

1. _____ Date: _____

2. _____ Date: _____

Option 2: Notary Public

In my presence on _____ (date), _____ (name) acknowledged his/her signature on this document or acknowledge that he/she authorized the person signing this document so sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

_____

Signature of Notary

Notary Stamp

_____**(Date/Initials)**