CHI St. Alexius Health

Devils Lake Hospital

INTRODUCTION

PRINT YOUR NAME

PRINT YOUR ADDRESS

INTRODUCTION

I, _____,
(name)

_____
(address)

understand this document allows me to do ONE OR BOTH of the following:

PART I: Name another person (called a health care agent) to make health care decisions for me if I am unable to make and communicate health care decisions for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or my agent must act in my best interest if I have not made my health care wishes known.

AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make and communicate decisions for myself.

In addition, I may also do the following, but I understand it is optional:

PART III: Allows me to make an organ and tissue donation upon my death by signing a document of anatomical gift.

PART I

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS FOR MYSELF (I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent).

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank. None of the following may be designated as your agent: your treating health care provider, a non-relative employee of your treating health care provider, an operator of a long-term care facility, or a non-relative employee of a long-term care facility.

ADD NAME OF HEALTH CARE AGENT, RELATIONSHIP, TELEPHONE NUMBER AND ADDRESS

When I am unable to make and communicate health care decisions for myself, I trust and appoint _____to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me:_____

Telephone number of my health care agent:_____

Address of my health care agent:_____

ADD ALTERNATE AGENT'S NAME RELATIONSHIP, TELEPHONE NUMBER AND ADDRESS

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If the person I have named above is not reasonably available or is unable or unwilling to serve as my health care agent, I trust and appoint

_____ to be my health care agent instead.

Relationship of my alternate health care agent to me:_____

Telephone number of my alternate health care agent:_____

Address of my alternate health care agent:_____

INSTRUCTIONS FOR HEALTH CARE AGENT

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS FOR MYSELF (I know I can change these choices).

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to make and communicate health care decisions for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive and deciding about mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S POWERS

ATTACH ADDITIONAL PAGES, IF NEEDED

INITIAL (1) IF YOU WANT YOUR AGENT TO BE ABLE TO MAKE DECISIONS REGARDING ORGAN DONATION

INITIAL (2) IF YOU WANT YOUR AGENT TO BE ABLE TO MAKE DECISIONS REGARDING THE FINAL DISPOSITION OF YOUR REMAINS

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

My health care agent is NOT automatically given the powers listed in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power: then my agent WILL HAVE that power.

_____ (1) To decide whether to donate any parts of my body when I die, including organs, tissues, and eyes.

_____(2) To decide what will happen with my body when I die (burial, cremation, etc.).

If I want to say anything more about my health care agent's powers or limits on those powers, I can say it here:

PART II

DESCRIBE YOUR BELIEFS AND VALUES ABOUT HEALTH CARE TO GUIDE HEALTH CARE DECISIONS ON YOUR BEHALF

ATTACH ADDITIONAL PAGES IF NEEDED

PART II: HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in part I, you MUST complete, at a minimum, Part II (B) if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to make and communicate health care decisions for myself. These instructions must be followed (so long as they address my needs).

(A) THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE
(I know I can change these choices or leave any of them blank).

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:

My fears about my health care:

DESCRIBE YOUR BELIEFS AND VALUES ABOUT HEALTH CARE TO GUIDE HEALTH CARE DECISIONS ON YOUR BEHALF

My spiritual or religious beliefs and traditions:

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

My thoughts about how my medical condition might affect my family:

(B) THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE
(I know I can change these choices or leave any of them blank.)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:
(NOTE: you can discuss general feelings, specific treatments, or leave any of them blank.)

If I had a reasonable chance of recovery and were temporarily unable to make and communicate health care decisions for myself, I would want:

_____

_____

_____

_____

DESCRIBE YOUR CHOICES REGARDING HEALTH CARE UNDER THE CIRCUMSTANCES DESCRIBED

If I were dying and unable to make and communicate health care decisions for myself, I would want:

_____

_____

_____

_____

If I were permanently unconscious and unable to make and communicate health care decisions for myself, I would want:

_____

_____

_____

_____

ATTACH ADDITIONAL PAGES IF NEEDED

If I were completely dependent on others for my care and unable to make and communicate health care decisions for myself, I would want:

_____

_____

_____

_____

DESCRIBE YOUR CHOICES REGARDING PAIN MANAGEMENT

In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:

_____

_____

_____

_____

_____

_____

There are other things that I would want or do not want for my health care, if possible:

Who I would like to be my doctor:_____

Where I would like to receive health care:_____

DESCRIBE YOUR CHOICES REGARDING HEALTH CARE UNDER THE CIRCUMSTANCES DESCRIBED

Where I would like to die and other wishes I have about dying:

_____

_____

_____

_____

_____

_____

ATTACH ADDITIONAL PAGES IF NEEDED

My wishes about what happens to my body when I die (cremation, burial, etc.):

_____

_____

_____

_____

_____

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Any other things:

PART III

PART III: MAKING AN ANATOMICAL GIFT (Optional)

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent, guardian, or your family may have the authority to make a gift of all or part of your body under North Dakota law.

INITIAL ONLY ONE

[_____] I do not want to be an organ donor at the time of my death, and do not want my family, guardian, or agent to donate my organs on my behalf.

[_____] I would like to be an organ donor at the time of my death. I have told my family my decision and ask my family to honor my wishes. I wish to donate the following (initial one statement):

INITIAL ONLY ONE

[_____] Any needed organs and tissue.

[_____] Only the following organs and tissue:

_____

_____

_____

PRIOR HEALTH CARE DIRECTIVES

PRIOR DIRECTIVE REVOCATION NOTICE

By executing this document, I hereby revoke any prior health care directive.

PART IV

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE WITNESSED, USE ALTERNATIVE NO. 1, BELOW (P. 12)

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE NOTARIZED, USE ALTERNATIVE NO. 2, BELOW (P. 13)

PART IV: EXECUTION

In order to make your Health Care Directive legally binding, you must sign your document, or direct someone to sign for you, in the presence of two witnesses or a notary, who must also sign the document.

Neither of the witnesses nor the notary public may be:

- A person you designate as your agent or alternative agent;
- Your spouse;
- A person related to you by blood, marriage, or adoption;
- A person entitled to inherit any part of your estate upon your death; or
- A person who has, at the time of executing this document, any claim against your estate.

If your document is witnessed, at least one of your witnesses must not be a health care or long-term care provider providing you with direct care or an employee of the health care or long-term care provider providing you with direct care.

You and any agent appointed in Part I must also sign a copy of the advance directive in Part V to accept his or her role in order for his or her power to become effective.

If you decide to have your advance directive witnessed, use alternative No. 1, below.

If you decide to have your advance directive notarized, use alternative No. 2, below.

(*This health care directive will not be valid unless it is notarized or signed by two qualified witnesses who are present when you sign or acknowledge your signature.* ***If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this health care directive.***)

DATE AND SIGN YOUR DOCUMENT HERE

YOUR WITNESSES MUST DATE AND PRINT YOUR NAME AND THEN SIGN AND DATE THE DOCUMENT AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST NOT BE YOUR HEALTH CARE PROVIDER OR EMPLOYEE OF YOUR HEALTH CARE PROVIDER

Alternative No. 1. Sign before witnesses

I sign my name to this Health Care Directive

on _____ at _____, _____.
(date) (city) (state)

_____
(signature of principal)

Witness One:

(1) In my presence on_____,
(date)
_____ acknowledged the
(name of declarant)
declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
(2) I am at least eighteen years of age.
I certify that the information in (1) and (2) is true and correct.

_____ _____
(signature of witness one) (date)

_____
(address of witness one)

Witness Two:

(1) In my presence on_____,
(date)
_____ acknowledged the
(name of declarant)
acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
(2) I am at least eighteen years of age.
(3) I am NOT a health care provider or an employee of a health care provider giving direct care to the declarant.
I certify that the information in (1) through (3) is true and correct.

_____ _____
(signature of witness two) (date)

_____
(address of witness two)

DATE AND SIGN YOUR DOCUMENT HERE

A NOTARY PUBLIC MUST FILL OUT THIS SECTION

Alternative No. 2. Sign before Notary Public

I sign my name to this Health Care Directive

on _____ at _____, _____.
(date) (city) (state)

_____
(signature of principal)

Notary Public

In my presence on_____, _____
(date) (name of declarant)

acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

_____
(signature of the notary public)

My commission expires _____, 20_____.

PART V

PART V. ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY

I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapacitated. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner.

If I choose to withdraw during the time the principal is competent I must notify the principal of my decision. If I choose to withdraw when the principal is not able to make health care decisions, I must notify the principal's physician.

YOUR AGENT AND ALTERNATE AGENT(S) MUST SIGN AND DATE THE DOCUMENT IN ORDER FOR THEIR POWER TO BE EFFECTIVE

_____ _____
(signature of agent) (date)

_____ _____
(signature of first alternate agent) (date)

_____ _____
(signature of second alternate agent) (date)

PRINCIPAL'S STATEMENT

I have read the materials explaining of the nature and effect of an appointment of a health care agent that are included in instructions to this health care directive.

Dated this _____ day of _____, 20_____

YOU MUST SIGN AND DATE THIS DOCUMENT HERE

_____
Signature of Principal

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898