

## Minnesota Catholic Health Care Directive

The following is the Minnesota Catholic Health Care Directive. It is an advance directive through which you can appoint a health care agent and express your wishes for spiritual support, medical care and treatment, pain-relieving medication, and, should you be unable to take food or drink orally, medically-assisted nutrition and hydration.

- Read the Directive carefully.
- Discuss your wishes with a person you would like to appoint as a health care agent and with others whom you would consider appointing as alternate health care agents.
- Fill out the Directive, but do not sign it yet.
- Ask two people to be your witnesses when you will sign the Directive, or have it notarized. If you are planning to travel to other states, it is recommended that you have the Directive notarized.
- After you have completed the Directive you should make a number of copies for your health care providers and the facilities to which they might refer you for treatment. Remember, you may need to present the Directive to several hospitals, and health care/living facilities.

### Instructions for My Health Care:

The Catholic faith teaches that human life is a precious gift from God. We are not its owners but its stewards. No one must ever presume to adopt a course of action or inaction that is intended to hasten my death, even if the motive is to alleviate my suffering. Having thought seriously about my beliefs and the principles that the Catholic Church teaches about end-of-life decision-making, I have set down the following instructions for my care for those who must make decisions for me should I become incompetent—that is, unable to make these decisions for myself. I have executed this document and intend to revoke any earlier health care directive or living will that I may have executed. I retain the right to revoke this document.

#### **Spiritual Support**

I request that my family, parish community, and friends support me through prayer and sacrifice, and that the sacraments of the Church be made available to me as I prepare for death or face serious illness. I wish to see a Roman Catholic priest and receive the Sacrament of the Sick (formerly called the “last rites”), as well as Confession and Communion.

#### **Medical Care and Treatment**

I wish to receive ordinary or proportionate care as a means of preserving my life. Proportionate means are those that offer a reasonable hope of benefit and do not entail an excessive burden to me—that is, they do not impose serious risk, excessive pain, prohibitive cost, or some other extreme burden. I oppose any act or omission that of itself or by intention will cause my death, even for the purpose of eliminating suffering. I direct that all decisions about my medical treatment and care be made in accord with Catholic moral teachings as contained in such documents as:

- *Care for Patients in a “Permanent” Vegetative State* (Saint John Paul II, March 20, 2004)
- *Declaration on Euthanasia* (Congregation for the Doctrine of the Faith, 1980)
- *Ethical and Religious Directives for Catholic Health Care Services* (U.S. Conference of Catholic Bishops, edition current at the time decisions are being made)

#### **Imminent Death from Terminal Illness**

If my death from a terminal illness is near at hand, I wish to refuse treatment that would only secure a precarious and burdensome prolongation of my life, so long as the ordinary care due me is continued.

#### **Food and Fluids (Nutrition & Hydration)**

If I am unable (even with assistance) to take food and drink orally, I desire that medically-assisted nutrition and hydration (MANH) be provided to me unless they cannot reasonably be expected to prolong life or when they would be excessively burdensome. Even if I am in a persistent vegetative state, MANH should be continued. MANH should be discontinued if it imposes excessive burdens to me (serious risk, excessive pain, prohibitive cost, or some other extreme burden), or if death is both inevitable and so imminent that continuing MANH is judged to be disproportionate care.

#### **Pain-Relieving Medication**

If my condition includes physical pain, I wish to receive pain-relieving medication in dosages sufficient to manage the pain, even if such dosages make me less alert or responsive, and even if managing my pain in this way is likely to shorten my life. No pain medication should be given to me for the purpose of hastening my death.

#### **Pregnancy**

If I am pregnant, I wish that steps be taken to preserve and nurture the life of my unborn child, including the continuation of life-sustaining procedures for the child.

Initials \_\_\_\_\_

Fill in the signature, printed name, and date lines below. Have two witnesses also sign and date this Minnesota Catholic Health Care Directive.

Signature (Principal) \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature (Witness #1) \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature (Witness #2) \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Note: Your appointed health care agent(s) may not serve as a witness to your declaration. A witness may not be someone who will benefit financially from your death.

### Appointment of My Health Care Agent

I (principal), \_\_\_\_\_ hereby designate and appoint:

Name (agent):	Relationship:
Address:	City/State/Zip:
Home Phone:	Work Phone:
Cell Phone:	Email:

### Alternate Agent (optional)

Name (agent):	Relationship:
Address:	City/State/Zip:
Home Phone:	Work Phone:
Cell Phone:	Email:

### Validation (Required)

Signature (Principal) \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature (Witness #1) \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature (Witness #2) \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Note: Your appointed health care agent(s) may not serve as a witness to your directive. A witness may not be someone who will benefit from your death.

### Optional Notarization

Notarization is not required by Minnesota but is recommended for those who travel to other states.

Sworn and subscribed to me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ My term expires:

(Notary)

### Authorization and Consent Under HIPAA

This advance directive is my direct authorization and consent under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and its regulations. I waive all rights to privacy under all federal and state laws and designate my agent as my personal representative under HIPAA, for the purpose of requesting, receiving, using, disclosing, amending, or otherwise having access to my personal, individually identifiable health information. I authorize any health care provider to release to my agent or to any person designated by my agent, all medical records of whatever nature, mental health records, billing statements, radiological films, pathology material, photographs, videos, and other information about me. This advance directive also authorizes any health care provider to speak to and disclose orally, to my agent and any person designated by my agent, any information about my diagnosis, care, treatment, prognosis, and opinions about me. It is my express intention that, to the greatest extent permitted by law, the authorization and consent provided herein will be effective for as long as this advance directive is effective. My personal health information may be used by my agent only for the purposes of making health care decisions on my behalf.