North Dakota Healthcare Directive Form

A healthcare directive, also known as an “advanced directive,” is a completely voluntary statement made by you (usually in writing) that gives directions to medical decision-makers and caregivers regarding the healthcare decisions to be made if you are unable to make those decisions for yourself. You may change or revoke your healthcare directive at any time.

Your healthcare directive is intended to reflect your healthcare wishes, preferences, goals, and values when you are unable to express them for yourself. That is why it is important to be clear and specific as you complete this healthcare directive.

There are two broad types of decisions that are contained within your healthcare directive.

The first type of decision is to appoint someone else—a “healthcare agent”—to make medical decisions for you (the “principal”) if you become unable to make decisions for yourself. This is commonly called a “durable power of attorney for healthcare.” Typically, your healthcare agent would be a family member or close friend who knows you, understands your values, and with whom you have discussed your healthcare preferences. Showing your healthcare directive to this agent and talking with that person and about what you do and do not want is an essential part of the healthcare directive process.

The second type of decision is whether you want life-prolonging treatment or nutrition and hydration started or continued if you are unable to communicate your wishes to your healthcare provider and you are in a terminal condition. This is often known as a “living will.” Common examples of the types of decisions included in the living will portion of a healthcare directive include Do-Not-Resuscitate (“DNR,” meaning no use of CPR), Do-Not-Intubate (“DNI,” meaning no use of a breathing machine), and where you would prefer to receive end-of-life care (at home or in a hospital/healthcare facility).

In addition, your healthcare directive may also state whether you would like to donate your organs, tissues, and/or eyes and whether you would like to be buried or cremated.

North Dakota statute provides a sample form to help you create a healthcare directive. Altru has made minor modifications to this statutory form to help make the process of developing a healthcare directive easier for you. If you need additional help completing your healthcare directive, please contact Altru’s Spiritual Care Office at (701) 780-5300.

HEALTHCARE DIRECTIVE

I_____ , understand this document allows me to do one or all of the following:

PART I: Name another person (called the healthcare agent) to make healthcare decisions for me if I am unable to make and communicate healthcare decisions for myself. My healthcare agent must make healthcare decisions for me based on the instructions I provide in this document (Parts II and III), if any; abide by the wishes I have made known to agent; and act in my best interest if I have not made my healthcare wishes known.

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

PART III: Make an organ and/or tissue donation upon my death by signing a document of anatomical gift.

PART I – HEALTHCARE AGENT

(NOTE: Complete this Part I only if you wish to appoint a healthcare agent. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II and/or Part III.)

Part I.A: Appointment of Healthcare Agent

My healthcare agent is who I want to make healthcare decisions for me if I am unable to make and communicate healthcare 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. If I do appoint an agent, I will discuss this healthcare directive with that person and give that person a copy.

(NOTE: None of the following may be designated as your agent or alternate agent: your treating healthcare provider, a nonrelative employee of your treating healthcare provider, an operator of a long-term care facility, or a nonrelative employee of a long-term care facility.)

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

Relationship of my healthcare agent to me: _____

Telephone number of my healthcare agent: _____

Address of my healthcare agent: _____

PART I.B: APPOINTMENT OF ALTERNATE HEALTHCARE AGENT (OPTIONAL)

If my healthcare agent is not reasonably available, I trust and appoint _____ to be my healthcare agent instead. This person is called my alternate healthcare agent.

Relationship of my alternate healthcare agent to me: _____

Telephone number of my alternate healthcare agent: _____

Address of my alternate healthcare agent: _____

PART I.C: POWERS OF HEALTHCARE AGENT

This is what I want my healthcare agent to be able to do if I am unable to make and communicate healthcare decisions for myself. I know I can change these decisions at any time.

My healthcare agent is automatically given the powers listed below in (A) through (D). My healthcare agent must follow my healthcare instructions in this document or any other instructions I have given to my agent. If I have not given healthcare instructions, then my agent must act in my best interest. Whenever I am unable to make and communicate healthcare decisions for myself, my healthcare agent has the power to:

(A) Make any healthcare 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 to start healthcare that is keeping me, or might keep me, alive and deciding about mental health treatment.
(B) Choose my healthcare providers.
(C) Choose where I live and receive care and support when those choices relate to my healthcare 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 healthcare 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: _____
_____
_____
_____

My healthcare agent is **not** automatically given the powers listed below 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, including organs, tissues, and eyes, when I die.

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

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

PART I.D: EXPLANATION OF HEALTHCARE AGENTS' POWERS AND RESPONSIBILITIES

Each person appointed by this document to serve as an agent for the principal's healthcare decisions is given power of attorney for healthcare only. Healthcare agents have a duty to act consistently with the desires of the principal as expressed in this appointment. This document gives appointed healthcare agents authority over healthcare decisions for the principal only if the principal becomes incapacitated. Healthcare agents must act in good faith in exercising authority under this power of attorney for healthcare. The principal may revoke this power of attorney at any time in any manner. If an appointed agent chooses to withdraw during the time the principal is competent, they must notify the principal of their decision. If an appointed agent chooses to withdraw when the principal is not able to make healthcare decisions, they must notify the principal's physician**.**

PART I.E: PRINCIPAL'S STATEMENT

By signing below, I attest that I have read and understand the foregoing written explanation of the nature and effect of an appointment of a healthcare agent(s). I understand that appointing an agent(s) is completely voluntary and that I may change or withdraw that appointment at any time. I further understand that I may change the powers or limitations on the powers of my appointed agent(s) at any time. With those understandings in mind, I wish to affirm the appointment of the healthcare agent(s) as set forth above.

Dated this _____ day of _____, 20____.

_____
(Principal's Signature)

PART II: HEALTHCARE INSTRUCTIONS

(NOTE: Complete this Part II only if you wish to give healthcare 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 healthcare directive.)

PART II.A: MY BELIEFS AND VALUES

These are instructions for my healthcare when I am unable to make and communicate healthcare decisions for myself. I want my healthcare agent(s) and/or healthcare providers to know these things about me to help you make decisions about my healthcare. These instructions must be followed so long as they address my needs. I know I can change these choices or leave any of them blank.

My goals for my healthcare: _____
_____
_____
_____

My spiritual or religious belief and traditions: _____
_____
_____
_____

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

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

PART II.B: WHAT I DO AND DO NOT WANT FOR MY HEALTHCARE

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 (intubation), artificial feeding or fluids through tubes, attempts to start a stopped heart (resuscitation), 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 healthcare in these situations. I understand that I can change these choices at any time. *(Note: You can discuss general feelings, specific treatments, or leave any of them blank.)*

If I had a reasonable chance of recovery and was temporarily unable to make and communicate healthcare decisions for myself, I would want: _____

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

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

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

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 want or do not want for my healthcare, if possible:

Who I would like to be my doctor(s):_____
_____

Where I would like to live to receive healthcare: _____
_____

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

What I would like to happen to my body when I die (cremation, burial, etc.): _____
_____
_____

Any other things: _____
_____
_____
_____

PART III – MAKING AN ANATOMICAL GIFT

(NOTE: Complete this Part III only if you wish to make an anatomical gift of organs and/or tissue at the time of your death. If you do not wish to make such a gift, you may leave this Part III blank and proceed to Part IV.)

I wish to be an organ and/or tissue donor at the time of my death. I have told my family and/or my healthcare agent(s) my decision, and I ask that they honor my wishes. I wish to donate the following organs and/or tissue (*initial by one statement)*:

_____ Any needed organs and tissue.

_____ Only the following organs and tissue: _____
_____

_____ Any needed organs and tissue *except* the following: _____
_____

PART IV – MAKING THE DOCUMENT LEGAL

PART IV.A – PRINCIPAL'S SIGNATURE

I revoke any prior healthcare directive. I sign my name to this healthcare directive form

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

_____
(Principal's Signature)

PART IV.B – NOTARY/WITNESS SIGNATURES

This document must be either (a) notarized or (b) witnessed by two (2) qualified adults. The person notarizing this document may be an employee of a healthcare or long-term care provider providing your care. If using qualified adult witnesses, at least one (1) witness to the execution of the document must not be a healthcare or long-term care provider providing you with direct care or an employee thereof.

(NOTE: If you have attached any additional pages to this healthcare directive form, you must sign and date each additional page at the same time you sign and date this healthcare directive form. None of the following may be used as a notary or witness: a person you designate as your healthcare agent or alternate; 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.)

Option 1: Notary Public

In my presence on _____ (date), _____ (name of principal) acknowledged the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf.

_____
(Signature of Notary Public)

My commission expires _____ , 20_____.

Option 2: Two Witnesses

Witness One:

(1) In my presence on _____ (date), _____ (name of principal) acknowledged the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf.

(2) I am at least eighteen (18) years of age.

(3) If I am a healthcare provider or an employee of a healthcare provider giving direct care to the principal, I must initial here: _____.

I certify that the information in (1) through (3) is true and correct.

_____ _____
(Signature of Witness One) (Address)

Witness Two:

(1) In my presence on _____ (date), _____ (name of principal) acknowledged the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf.

(2) I am at least eighteen (18) years of age.

(3) If I am a healthcare provider or an employee of a healthcare provider giving direct care to the principal, I must initial here: _____.

I certify that the information in (1) through (3) is true and correct.

_____ _____
(Signature of Witness Two) (Address)