Please read the following instructions carefully

There are several steps to complete. Each is important. Take your time.

This is your legal document, created with your answers from the inventory.
Allina Health assumes no responsibility for the answers in the final document.

☐ when step is done

1) Make changes until the document reflects your wishes. ☐

You can make changes at any time by returning to the Health Care Directive within your account. Take your time. If you like, you may share your draft with your loved ones and health care agent(s). If you have questions, you may also want to talk with your health care provider.

2) Print and review the document. ☐

Print a final copy. Review each page. There may be stat-specific choices that are required, such as checking a box or initializing a line. Complete those areas as needed.

3) Sign the document. ☐

To make the document legal, complete your health care directive and sign it in front of two witnesses or a notary public.

4) Give copies of your document to your health care agent(s), health care provider(s) and loved ones. ☐

To make sure your wishes will be followed, it is important that you communicate your choices to those who need to know. Make copies of your health care directive and give them to your health care agent(s), health care provider(s) and loved ones.

Consider having a meeting to share your wishes. Include your health care agents and loved ones. Not only will it make sure there is a shared understanding of your wishes, it will allow you to go through the process once, rather than needing to repeat it. Everyone will hear the same message. This can help prevent conflict down the road.

5) Make sure your documents can be found.

Your directive will serve and protect you only if it can be found when it is needed. Online storage provides the greatest level of accessibility.

A) Online with your account ☐

Keeping you completed and signed health care directive online lets you:

- store it in a safe online space at no charge
- change it at any time by accessing your account
- share it with the people whom you wish to authorize to have online access to your health care directive. You can invite these people to your account by completing the Share step.

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B) Hard copy in a location that is easy to find. ☐

Put your original document in a well-labeled folder at home. Tell at least one person where the folder is. Putting it in a safety deposit box is not helpful.

6) Make sure your health care directive goes in your medical record. ☐

Your health care directive will not automatically be added to your medical record, so please bring a copy to your clinic the next time you have an appointment.

Congratulations! You've given your loved ones, and yourself, a gift of peace of mind.

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Health Care Directive

PART 7: My Information (I am called the "Principal")

This part of your health care directive comes from your account profile.

DENNIS STOCKDALE
1426 GLENHILL RD
ROSEVILLE, MN
55112

Birthdate: 10/26/1949

Primary phone: 9529207070

Declaration

I, DENNIS STOCKDALE, have created this document with much thought given to my treatment choices and personal preferences if I cannot communicate my wishes or make my own health care decisions.

Any health care directive document created before this is no longer legal or valid.

This document was completed when I am:

in fair to poor health and living with serious illness.

Note: This document will not apply to any intrusive mental health treatments, defined as electroconvulsive therapy or neuroleptic medications.

My Health Care Agent(s)

This part of your health care directive comes from the My Health Care Agent(s) section.

Selection of my agent(s) (also called "representative", "proxy" or "surrogate"):
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 have appointed a health care agent to speak for me.

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- When choosing my health care agent(s) I have considered their ability to willingly make decisions while being aware of my treatment choices. My health care agent(s) can follow my wishes under times of stress.
- I understand that my agent(s) must be 18 years of age or older.

My choice for the type of health care agent(s):

- I understand that my health care agent(s) cannot be a health care provider (or employee of a health care provider) giving care to me or my spouse uless I am related to that person by blood or marriage, registrered domestic partnership or adoption; or provide a clear reason why I want that person to serve as my agent. If my agent is a health care provider (or an employee of a health care provider), my reason for choosing him or her is:

  Regarding my choice for the type of health care agent(s):

  I choose to designate a primary health care agent who will make decisions on his or her own. I may also choose an alternate health care agent who will serve if the primary health care agent cannot be reached.

  Final decision making authority:

As my **primary health care agent,** I have chosen:

Health Care Agent Name:

David Stockdale

Relationship to me:

Brother

Contact information:

David Stockdale 612/363-7747

As my **first alternate health care agent,** I have chosen:

Health Care Agent Name:

Relationship to me:

Contact information:

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As my **second alternate health care agent,** I have chosen:

Health Care Agent Name:

Relationship to me:

Contact information:

Authority for My Health Care Agent(s)

This part of your health care directive comes from the My Health Care Agent(s) section.

My health care agent(s) automatically has the following powers when I am unable to make my own health care decisions.

- Consent, refuse or withdraw consent for decisions about my health care. This includes tests, medicines, surgery, taking out or not putting in tube feedings, and other decisions related to treatments. 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 health care as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Minnesota Health Records Act.
- Arrange for my health care and treatment in any other state or location he or she thinks is appropriate.
- Decide which health care providers and organizations provide my care.
- In addition to these powers, I authorize my health care agent(s) to make decisions about organ and tissue donation and autopsy according to the guidelines I have chosen later in the My Health Care Instructions section of this document.

Additional powers of my health care agent(s):

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

Limitations for the authority given to my health care agent(s):

I strongly ask that my decisions are not revoked or overridden in a crisis. I know that I cannot legally forbid this, but I am asking in the strongest terms that my wishes are honored.

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My Health Care Instructions

This part of your health care directive comes from the My Health Care Instructions section.

My end-of-life health care choices and preferences are recorded below to guide the decisions of my health care agent(s) and my health care team. I have made these choices thoughtfully and ask that my wishes be honored and followed by my health care agent(s) and team to the best of their ability. I may have included supporting information and preferences in an Addendum to this document. I also ask that all decisions be explained to me, even if I appear unresponsive.

A. Vegetative State:

If I can no longer make decisions for myself, my health care team and health care agent(s) believe I will not recover my ability to know who I am and/or I have permanent brain injury with little chance of regaining consciousness (persistent vegetative state),

My instructions for medical intervention are as follows:

I would 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.

B. Terminal Illness:

I would 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.

C. Cardiopulmonary Resuscitation (CPR):

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. I understand that: CPR can save a life but does not always work, and CPR does not work as well for people who have chronic (long-term) diseases, and recovery from CPR can be painful and difficult. Therefore:

I want CPR attempted if my heart or breathing stops unless my health care provider determines I have an incurable illness or injury and am dying, 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 then process of CPR would cause significant suffering.

D. Artificial Nutrition and Hydration:

If my health care team believes I will not recover and that artificial nutrition (food) and hydration (water) will only extend my death, I don't want to have it.

E. Organ Donation:

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I do want to donate any or all of my organs, tissues or other body parts. I authorize this donation after I die. My health care agent(s) is authorized to initiate and/or continue supportive treatments or any interventions necessary to maintain the viability of my organs, tissues and eyes, until donation has been completed.

F. Autopsy:

I do authorize my health care agent(s) to request an autopsy if it can help others understand the cause of my death or help my family members make decisions about their future health care.

G. My remains:

I want to be cremated. I authorize my health care agent(s) or those making decisions after my death to make arrangements for my cremation.

H. Additional instructions for my health care:

I ask my medical team to speak openly and honestly with my loved ones and health care agent(s). Please give them all of the pros and cons of the treatment options. I would like my health care agents and medical team to transition my care to hospice care sooner than later. I believe hospice will provide the best quality of life for the time I have left and support me through the dying process. If possible, I would like to die at home, and I know that might be uncomfortable for my family and friends. I want comfort (palliative) care that manages my pain and discomfort.

My Quality of Life

This part of your health care directive comes from the My Quality of Life section.

I ask my health care agent(s), health care team and loved ones to honor how I define my quality of life. The statements below may guide choices regarding the care I receive.

A. Mobility and awareness:

I believe I can live well and still have an acceptable quality of life if I have full mobility and do not need help. I am able to engage in all of my normal social and/or work activities. I can drive a vehicle and travel on my own. Full mobility is important to my definition of living well.

B. Independence:
Activities of daily living:

I believe I can live well and still have an acceptable quality of life if I can live independently without help and I am able to manage all of my daily activities. Living independently is important to my definition of living well.

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Dependence values

I believe I can live well and still have an acceptable quality of life if I am able to function without routine mechanical assistance. Living well means I am not dependent on any machines to survive. Being free from all machines is important to my definition of living well.

C. Communication values:

I believe I can live well and still have an acceptable quality of life if I am fully able to communicate. I can speak, use body language and write to communicate my needs. Being able to communicate is important to my definition of living well.

D. Cognitive Awareness values:

I believe I can live well and still have an acceptable quality of life if I recognize my loved ones all of the time (100%). I know their names and the relationships I have with my loved ones. I can recall our relationship history and have meaningful conversation. Recognizing my loved ones is important to my definition of living well.

E. Pain management values:

I believe that I can live well and still have an acceptable quality of life if my pain is managed as aggressively as needed to ease my suffering. I want care that strongly manages my pain and discomfort. My top priority is pain and symptom management, even if that hastens my death.

F. Values and Beliefs:

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

Friends and family who are kind and encouraging. MUSIC GRATITUDE

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

TBD

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

I would like to die without being a burden or hardship to anyone. Comfort and pain management are important.

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.):

TBD

Religious affiliation:

TBD

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I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

TBD

G. Additional instructions on my quality of life:

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Making Your Health Care Directive Legal in Minnesota

Signature or Verification

Note: Wait to sign you name until you are in the presence of either two witnesses or a Notary Public.

I am at least 18 years of age. This document was completed at a time when I was: in good health with no medical problems or conditions. I am signing this Health Care Directive as follows:

Signature: Date signed:

If I cannot sign my own, I ask the following person to sign for me.

Signature (of person asked to sign):

Printed Name:

Signature of Witnesses or Notary Public

Note: In order for your document to be legally valid, at least two adult witnesses or a Notary Public must witness the signing of this document and then sign it.

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Alternate 1: Two Witnesses

If you choose this method of legal verification of your health care directive, two adult witnesses must witness the signing of this document and then sign the following declaration. The witnesses **cannot** be someone:

- you appointed as your health care agent.
- younger than 18 years of age.

Under penalty of perjury under the laws of my state, I declare that:

This document was signed or verified in my presence. I certify that I am 18 years of age, ***and I am not appointed as a primary or alternate 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: _____. One witness cannot be a health care provider or an employee of the health care provider giving direct care on the date this document is signed.*

Signature of Witness 1:

Printed Name:

Address: Date signed:

Signature of Witness 2:

Printed Name:

Address: Date signed:

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Alternate 2: Notary Public

The undersigned, being a Notary Public certified in Minnesota, declares that the person making this health care directive has dated and signed or marked it in my presence or has 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.

Subscribed and sworn to before me on this _____ day of _____, _____
dd *mm* *yyyy*

County of:

WITNESS MY HAND AND SEAL:

Notary Signature:

My commission expires (date): Notary stamp:

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Health Care Directive Addendum for DENNIS STOCKDALE

My Story

Though not part of my legal health care directive, I ask my health care agent(s), health care team and loved ones to honor my values and beliefs, wishes and hopes included in this addendum.

A. Loved Ones:
This part of your health care directive comes from the Loved Ones section.

The following messages are intended to guide my health care agent(s) and to comfort my loved ones.

My Care Preferences:

I do not wish to be a burden. My roommate and friend, John Franken, has been extremely kind and accepting. His music has been a comfort to me and I would like to die at home if possible.

My Thoughts on Death and Dying:

I have lived a good life even with the challenges and struggles. I hope that some of my efforts to create a kinder world have made a difference.

Additional messages for my love:

Please respect my wishes even if you disagree with my choices. Please do not let me suffer. To my friends and family: Be kind. Gratitude can be found in any situation. Encouragement Matters and Kindness Counts

B. Personal Care:
This part of your health care directive comes from the Personal Care section.

The following are my wishes for how the people caring for me can provide personal care, emotional, and spiritual support.

My Wishes for Personal Hygiene:

TBD

My Wishes for Comfort and Emotional Support:

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TBD

My Wishes for Spiritual Care:

TBD

Additional information for my personal care:

C. Celebrating My Life:

This part of your health care directive comes from the Celebrating My Life section.

The following messages are intended to guide my loved ones after I am gone.

My Wishes for My Service:

The celebration of my life is not important to me. I lived a principal centered life and believe my contributions have made a positive difference. The life celebration is about those I leave behind and the memories they want to memorialize and celebrate. I do wish to be cremated/ I want my family and friends to know they are loved and deeply appreciated. Gratitude forever.

My Wishes for Remembering Me:

TBD

My Obituary:

Not important to me.

Anything else regarding celebrating my life:

D. Providers:

This part of your health care directive comes from the Providers section.

Health Care Providers:

Health care provider's name and clinic/hospital location:

Dr. Jack Beaird has been my primary care provider since my health became a concern. He has been the leader of my health care team and has been kind and compassionate. He has a good understanding of my chronic conditions. He is located at the Richfield Allina Clinic.

Alternate health care provider's name and clinic/hospital location

Dr. Maus, Richfield Allina Clinic

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Where should I receive hospital care:

Medical or care facility name and address:

My preferred hospital: United Hospital St. Paul, Mn.

Alternate medical or care facility name and address:

Preferred Care Center (when traveling) name and address:

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