Honoring Choices®
MINNESOTA
An initiative of the Twin Cities Medical Society.

# Minnesota Lub Tsev Hauj lwm Saib Xyuas Mob Nkeeg Txog Daim Ntawv Sau Qhia Kho Mob

*(MN Health Care Directive for Patients with a Chronic/Serious Illness)*

- Daim ntawv no hloov rau txhua daim ntawv sau txog kev saib xyuas mob nkeeg uas sau ua ntej daim no**.** *(This document replaces any health care directive made before this one.)*
- Daim ntawv no tsis siv rau kev kho mob nrog hluav taws xob (electroconvulsive) los sis kho mob hlwb (neuroleptic) rau kev puas hlwb. (*This document doesn't apply to electroconvulsive therapy or neuroleptic medications for mental illness.)*
- Kuv yuav muab ib co ntawv theej rau kuv cov chaw saib xyuas mob nkeeg thiab pawg kws saib xyuas mob nkeeg thaum ua tiav. *(I will give copies to my health care agents and health care teams when completed.*)
- Kuv yuav sau ib daim ntawv tshiab hais txog kev saib xyuas mob nkeeg yog kuv cov chaw kho mob, cov hom phiaj, kev nyiam, los sis cov lus qhia txawv txav. (*I will make a new health care directive if my agents, goals, preferences, or instructions change.)*

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Kuv Lub Npe thiab Xeem *(Name)*____________________ Kuv Lub Hnub Yug *(date of birth)*: _______________

Kuv Qhov Chaw Nyob *(Address)*_________________________________________________________________

Xovtooj ntawm tes # *(Cell #)* _______________ Hauv Tsev # *(Home #)*______________

Chaw ua haujlwm # *(Work #)*_______________

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## Kuv Cov Neeg Sawv Cev Saib Xyuas Mob Nkeeg

*(My Health Care Agents)*

Kuv tus neeg sawv cev saib xyuas mob nkeeg yog tus ua hauj lwm tam rau kuv tau yog kuv tus kheej tsis tuaj yeem txiav txim siab txog kev kho mob rau kuv tau lawm. Kuv ntseeg tias kuv tus neeg sawv cev **yuav yog kuv tus kws qhia,** yuav **ua raws li kuv cov lus qhia,** thiab yuav txiav **txim siab raws li yam kuv xav tau**. Kuv cov neeg sawv cev yuav tsum muaj hnub nyoog tsawg kawg yog 18 xyoo. Yog kuv xaiv kuv tus kws kho mob yog tug neeg sawv cev tam, Kuv muaj lub lawj thawj (reason) raws li hauv qab no.

*(My health care agent is my voice if I can't make health care decisions for myself. I trust my agent to **be my advocate,** to **follow my instructions,** and to **make decisions based on what I would want**. My agents are at least 18 years old. If I chose my health care provider to be an agent, I have given my reason below.)*

**Tus Neeg Sawv Cev Saib Xyuas Mob Nkeeg** *(Health Care Agent)*

Lub Npe *(Name)*_________________________ Kev txheeb ze rau kuv *(Relationship to me)* __________________

Chaw nyob *(Address)*___________________________________________________________________________

Xovtooj ntawm tes # *(Cell #)* ________________________ Chaw ua haujlwm # *(Work #)*___________________

Hauv Tsev # *(Home #)*________________

Lub Npe (Name)________________ Hnub Tim (Date)____________

**Thawj Txoj Hau Kev Xaiv Tus Neeg Sawv Cev Saib Xyuas Mob Nkeeg**—Yog kuv tus neeg saib xyuas mob nkeeg tsis txaus siab, tsis tuaj yeem ua tau, los sis tsis khoom. *(First alternate health care agent—if my health care agent isn't willing, able, or reasonably available.)*

Lub Npe *(Name)*________________________ Kev txheeb ze rau kuv *(Relationship to me)* _________________

Chaw nyob *(Address)*________________________________________________________________________

Xovtooj ntawm tes # *(Cell #)* _______________________ Chaw ua haujlwm # *(Work #)*__________________

Hauv Tsev # *(Home #)*________________

**Tus Neeg Sawv Cev Saib Xyuas Mob Nkeeg Thib Ob—**Yog kuv thawj tus neeg saib xyuas mob nkeeg tsis txaus siab, tsis tuaj yeem ua tau, los sis tsis khoom. *(Second alternate health care agent—if my first alternate agent isn't willing, able, or reasonably available.)*

Lub Npe *(Name)*________________________ Kev txheeb ze rau kuv *(Relationship to me)* _________________

Chaw nyob *(Address)*________________________________________________________________________

Xovtooj ntawm tes # *(Cell #)* _______________________ Chaw ua haujlwm # *(Work #)*__________________

Hauv Tsev # *(Home #)*________________

**Vim li cas kuv thiaj li xaiv cov neeg sawv cev saib xyuas mob nkeeg no** *(Why I chose these health care agents):*

_____________________________________________________________________________________

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## Cov Neeg Sawv Cev Saib Xyuas Mob Nkeeg: Lub Hwj Chim thiab Thaum Muaj Tej Yam Tshwj Xeeb

*(Health Care Agents: Powers and Special Situations)*

Yog kuv tsis tuaj yeem txiav txim siab saib xyuas mob nkeeg rau kuv tus kheej tau, kuv tus neeg sawv cev saib xyuas mob nkeeg tuaj yeem: tau txais kuv cov ntaub ntawv kho mob teev tseg, txiav txim siab thaum yuav pib kho mob thiab tso tseg kho mob, thiab xaiv kuv pawg kws saib xyuas mob nkeeg thiab muab kev saib xyuas rau kuv. *(If I'm not able to make my own health care decisions, my health care agent can: access my medical records, decide when to start and stop treatments, and choose my health care team and place of care.)*

**Kuv kuj xav kom kuv tus neeg sawv cev saib xyuas mob nkeeg mus ua** *(I also want my health care agent to)***:**

☐ Txiav txim siab txog cev xeeb menyuam zaum txuas mus ntxiv yog kuv tus kheej tsis tuaj yeem txiav txim siab tau. (*Make decisions about continuing a pregnancy if I can't make them myself.)*

☐ Txiav txim siab txog kev saib xyuas kuv lub cev tom qab tag sim neej (kev phais thaum tuag lawm, kev faus, kev hlawv lub cev) *(Make decisions about the care of my body after death—autopsy, burial, cremation).*

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Lub Npe (Name)________________ Hnub Tim (Date)____________

**Kev Saib Xyuas Kuv Rau Yav Tom Ntej Thaum Kuv Tsis Nco Qab Lawm Li**

*(My future care preferences if I'm permanently unconscious)*

Kev tsis nco qab lawm li tuaj yeem tshwm sim tau los ntawm ib qhov xwm txheej raug teeb meem (accident), mob hlab ntsha tawg, thiab lwm yam mob. Kuv pawg kws saib xyuas mob nkeeg hu qhov no tias **nyob rau kis tsis nco qab mus ib txhis.** Qhov no txhais tau tias lub hlwb raug mob phem uas ua rau tus neeg no tsis paub nws tus kheej los sis tsis paub lwm tus neeg, tsis nkag siab los sis tsis tuaj yeem tham nrog lwm tus neeg tau, thiab pawg kws saib xyuas mob nkeeg ntseeg tias tus neeg no yuav zoo tsis taus rov los lawm.
*(Permanent unconsciousness can be caused by an accident, a stroke, and other illnesses. My health care team may call this a **permanent vegetative state.** This means the brain is so badly hurt that the person isn't aware of self or others, can't understand or communicate, and the health care team believes the person won't get better.)*

Kev kho mob los ntawm tej yam khoom siv los sis khoom siv cuav tuaj yeem ua rau ib tug tib neeg muaj txoj sia nyob tau thaum lub cev tsis tuaj yeem ua hauj lwm lawm. Piv txwv muaj li: kev ua pa (tshuab pab ua pa) thaum cov ntsws tsis ua hauj lwm, kev pab nias kom lub plawv nres lawm rov ua hauj lwm (CPR) tau, kev tso cua ua pa raws cov thoj yas ua pa, kev tso zaub mov yug lub cev raws txoj thoj yas (IV), thiab kev lim ntshav thaum ob lub raum tsis ua hauj lwm.
(*Mechanical or artificial treatments may keep a person alive when the body can't function on its own. Examples are: ventilation (breathing machine) when the lungs aren't working, cardiopulmonary resuscitation (CPR) to try to restart a heart that has stopped beating, artificial feeding through tubes, intravenous (IV) fluids, and dialysis when the kidneys aren't working.)*

**Yog tias kuv tsis tsim rov qab** *(if I'm permanently unconscious):*

☐ **Kuv xav kom qee los sis txhua qhov kev kho mob pab txoj sia nyob ruaj ntseg** yog tias kuv tsis tsim rov qab los lawm. Kuv tus neeg sawv cev saib xyuas mob nkeeg yuav tsum ua hauj lwm nrog kuv pawg kws saib xyuas mob nkeeg los mus muab kev txiav txim siab hais txog kev kho mob rau kuv raws kuv cov hom phiaj thiab kev ntseeg muaj nuj nqi. (***I want some or all possible life-sustaining treatments** if I'm permanently unconscious. My health care agent should work with my health care team to make decisions about treatments based on my goals and values.)*

***LOS SIS (OR)***

☐ **Kuv tsis xav tau kev kho mob pab txoj sia nyob ruaj ntseg** yog tias kuv tsis tsim rov qab los lawm. Npaj ua kom kuv nyob nyab xeeb thiab cia kuv tag txoj sia raws li keeb kwm tuag.*(**I don't want life-sustaining treatments** if I'm permanently unconscious. Focus on making me comfortable and allow natural death.)*

***LOS SIS (OR)***

☐ **Kuv tsis tuaj yeem txiav txim siab txog qhov kev kho mob pab txoj sia nyob ruaj ntseg** yog tias kuv tsis tsim rov qab los lawm. Kuv tus neeg sawv cev saib xyuas mob nkeeg yuav tsum ua hauj lwm nrog kuv pawg kws saib xyuas mob nkeeg txiav txim siab puas muaj kev kho mob pab txoj sia nyob ruaj ntseg los sis tsis muaj cov kev kho mob raws li kuv cov hom phiaj thiab kev ntseeg muaj nuj nqi. *(**I can't make a decision now about life-sustaining treatments** if I'm permanently unconscious. My health care agent should work with my health care team to decide whether or not to use life-sustaining treatments based on my goals and values.)*

Lub Npe (Name)________________ Hnub Tim (Date)____________

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### Kev Muab Khoom Hauv Nruab Nrog Cev Pub Rau Lwm Tus

*(Organ Donation)*

☐ **Kuv xav muab kuv ob lub qhov muag, cov npluag nqaij thiab/los sis cov khoom hauv nruab nrog cev pub rau lwm tus, yog kuv tuaj yeem muab tau.** Kuv tus neeg sawv cev saib xyuas mob nkeeg yuav pib thiab txuas ntxiv *kev* kho mob rau kuv tom qab kev muab khoom nruab nrog cev pub rau lwm tus tiav lawm. ***(I want to donate my eyes, tissues and/or organs, if I can.*** *My health care agent may start and continue any treatments needed until the donation is complete.)*

☐ **Kuv tsis kam muab kuv ob lub qhov muag, cov npluag nqaij thiab/los sis cov khoom hauv nruab nrog cev pub rau lwm tus.** *(I don't want to donate my eyes, tissues and/or organs.)*

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### Lwm Yam Lus Qhia Ntxiv

*(Additional instructions)*

☐ Kuv tau muab #______ nplooj ntawv tso nrog) cov lus qhia ntxiv rau cov ntaub ntawv no.

*(I have attached #______ page(s) of additional instructions to this document.)*

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### Kev Sau Cov Ntaub Ntawv Raug Cai No

*(Making this document legal)*

**1. Kos npe thiab hnub tim** *(Sign and date)*:

______________________________________ ______________________________

Kuv kev Kos Npe *(My signature)* Hnub Tim Kos Npe *(Date signed)*

**2. Kom muaj 2 tug neeg ua pov thawj lees paub koj qhov kos npe LOS SIS tau pom zoo nrog.**
*(Have your signature notarized OR verified by 2 witnesses)*

**MINNESOTA NOTARY PUBLIC**
*(TSOOM FWV MINNESOTA QHOV KEV LEES PAUB)*

County of ________________________________________(county name)
In my presence on the date of ______________________(date notarized)
________________________________________(person signing above)
acknowledged their signature on this document. I am not named as a healthcare agent in this document.

*(Cheeb tsam nroog ntawm ___________(lub npe cheeb tsam nroog).*
*Hauv hnub tim kuv hais ______________(hnub lees paub)*
*_______________________________(tus neeg kos npe saum toj sauv)*
*tau lees paub lawv qhov kev kos npe rau daim ntawv no. Kuv tsis yog tus sau npe yog tus neeg sawv cev saib xyuas mob nkeeg tus sawv cev nyob hauv cov ntaub ntawv no.)*

**NOTARY SEAL BELOW**
*(NTAUS THWJ DAIM NTAWV LEES PAUB HAUV QAB NO)*

***Signature of Notary*** *(Kos Npe ntawm Tus Neeg Lees Paub)*________________________________________

Lub Npe (Name)________________ Hnub Tim (Date)____________

***LOS SIS (OR)***

**COV LUS NTAWM TUS NEEG UA POV THAWJ:** Kuv hnub nyoog tsawg kawg yuav tsum muaj 18 xyoo. Kuv tsis yog tus sau npe yog tus neeg sawv cev saib xyuas mob nkeeg nyob hauv cov ntaub ntawv no. Tsuas muaj ib tug neeg ua pov thawj thiaj li yog ib tug neeg ua hauj lwm ntawm feem saib xyuas mob nkeeg uas los muab kev saib xyuas mob nkeeg rau hnub no.

***(STATEMENT OF WITNESSES:*** *I am at least 18 years old. I am not named as a health care agent in this document. Only one witness can be an employee of the health care system providing care to the person on this date.)*

Tus Neeg Ua Pov Thawj # 1 Kos Npe *(Witness # 1 Signature)* ____________________________________

Hnub Tim Kos Npe *(Date Signed)*______________________________

Sau Npe *(Printed Name)* _____________________________________

Tus Neeg Ua Pov Thawj # 2 Kos Npe *(Witness # 2 Signature)* ____________________________________

Hnub Tim Kos Npe *(Date Signed)*______________________________

Sau Npe *(Printed Name)* _____________________________________