



(Minnesota Health Care Directive – Standard version)

- **Macluumaadkani wuxuu bedelayaa nooc kata oo ku saabsan wakiilasho daryeele caafimaad oo la sameeyey kan ka hor.** *(This document replaces any health care directive made before this one.)*
- Dukumentigaan ma quseyo daaweynta electroconvulsive ama daaweynada dhimirka ee loogu talagalay dadka maskaxda ka jiran. *(This document doesn't apply to electroconvulsive therapy or neuroleptic medications for mental illness.)*
- Waxaan siin doonaa qoraal koobi ah Wakiilkayga daryeelka caafimaad iyo kooxda daryeelka caafimaadkayga markii la dhammeystiro. *(I will give copies to my health care agents and health care teams when completed.)*
- Waxaan samaysan doonaa daryeele cusub daryeelkayga caafimaad haddii ay wax iska bedelaan qorshahayga fog, doorshadayda, ama Hab raacayga guud. *(I will make a new health care directive if my agents, goals, preferences, or instructions change.)*

Magaca (full name): _____ **Taariikhda Dhalasheyda** (date of birth): _____

Ciwaanka (address): _____ **Guriga #** (home) _____

Telefoonka gacanta # (cell) _____ **Shaqada #** (work) _____

Wakiiladayda Daryeelkayga Caafimaadka

(My health care agents)

Wakiilka daryeelka caafimaadka waa codkeyga haddii aan aniga sameyn Karin go'aamada nafteyda. Waxaan aaminsanahay **inuu noqdo qarankeyga, si aan u raaco tilmaamaha, iyo si sameynta go'aamada ku saleysan waxa aan u baahanahay.** Wakiiladeyda ugu yaraan 18 sano jir. Haddii aan doorto bixiyaha daryeelka caafimaadkeyga inuu wakil iga noqdo, waxaan siinaya sababa hoos.

*(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.)*

Wakiilka Daryeelka Caafimaadka *(Health care agent)*

Magaca (full name) _____

Wawaxa aan isku nahay (Relationship to me) _____

Ciwaanka (address) _____ **Guriga #** (home) _____

Telefoonka gacanta # (cell) _____ **Shaqada #** (work) _____

Magaca (Name) _____ **Taariikhda** (Date) _____

Qofka kale ee Koowaad ee Wakiilka Daryeelka Caafimaadka—Haddii wakiilkeyga caafimaadka uusan rabin, awoodin, surtagal aheyn in la helo. *(First alternate health care agent—if my health care agent isn't willing, able, or reasonably available.)*

Magaca (full name) _____

Wawaxa aan isku nahay (Relationship to me) _____

Ciwaanka (address) _____ **Guriga #** (home) _____

Telefoonka gacanta # (cell) _____ **Shaqada #** (work) _____

Qofka kale ee Labaad ee Wakiilka Daryeelka Caafimaadka—Haddii wakiilkeyga caafimaadka uusan rabin, awoodin, surtagal aheyn in la helo. *(Second alternate health care agent—if my first alternate agent isn't willing, able, or reasonably available.)*

Magaca (full name) _____

Wawaxa aan isku nahay (Relationship to me) _____

Ciwaanka (address) _____ **Guriga #** (home) _____

Telefoonka gacanta # (cell) _____ **Shaqada #** (work) _____

Sababta aan u Doortay Wakiilada daryeelka Caafimaadkaan: *(Why I chose these health care agents):*

Wakiilada Daryeelka Caafimaadka: Awoodaha iyo Xaaladdaha Gaarka ah

(Health Care Agents: Powers and Special Situations)

Haddii aan awoodin inaan sameyo go'aamadeyda daryeelka caafimaadka, wakiilka daryeelka caafimaadka ayaa awoodda: isticmaali kara diiwaanada caafimaadkeyga, go'aamiyo markii aan bilaabayso iyo marka aan joojinayo daaweynta, iyo doorashada kooxda daryeelka caafimaadkeyga iyo goobta daryeelka. *(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.)*

Waxaan sidoo kale rabaa wakiilka daryeelka caafimaadkeyga inuu *(I also want my health care agent to):*

- Samey go'aamada ku saabsan sii wadista uurka haddii aan sameyn karin. *(Make decisions about continuing a pregnancy if I can't make them myself.)*
- Samey go'aamada ku saabsan daryeelka jirka kadib dhimashada (baarisa, duugta, gubida). *(Make decisions about the care of my body after death—autopsy, burial, cremation).*

Magaca (Name) _____ Taariikhda (Date) _____

Doorkayga Daryeelkeyga Mustaqbalka Haddii aan Gabi ahaan Miir Daboolmo

(My Future Care Preferences if I'm Permanently Unconscious)

Miir daboolmida Joogtada ah waxaa keeni kara shiil, istrook, iyo xanuunada kale. **Kooxdeyda daryeelka caafimaadka waxaa ugu yeeri karaan Xaaladd miyir daboolid joogto ah.** Tani waxay ka dhigan tahay inay maskaxda ay six xun u dhawancan tahay qof ma iska warqabo ama kuwa kale, ma fahimi karo ama ma hadli karo, iyo kooxda daryeelkeyga caafimaadka waxay rumeysanyihiin in uu qofka uu soo kabaneynin.

*(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.)*

Farsamada iyo daaweynta macmalka ah ayaa ka dhigi karaa qofka inuu noolaado marka uu jirka shaqeyneynin. Tusaale ahaan: hawada (mashiinka neefta) marka ay sababada shaqeynaynin, wadno soo celinta (CPR) si lag isku dayo inuu dib dib u shaqeyo marka uu joojiyo garaacida, ku quudinta tuubyada macmalka ah, cabitaanada xidida laga qaato, iyo kilyo dhaqimada markii ay kilayaha shaqada joojiyaan.

(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.)

Haddii aan si joogto ah u miir beelo *(if I'm permanently unconscious):*

- Waxaan rabaa qaar ama dhammaan daaweynta taageerida-nolosha** haddii aan si joogto ah u miir daboolmo. Wakiilka daryeelka caafimaadkeyga waa inuu la shaqeyaa kooxdeyda daryeelka caafimaadka si loo go'aamada ku saleysan daaweynta hadafyada iyo heerarka. ***(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.)***

AMA *(OR)*

- Ma rabo daaweynta taageerida-nolosha** haddii aan si joogto ah miir daboolmo. Xooga saar inaad ii qanciso aniga iyo ii ogolow dhismada dabiiciga ah. ***(I don't want life-sustaining treatments if I'm permanently unconscious. Focus on making me comfortable and allow natural death.)***

AMA *(OR)*

- Hadda ma sameyn karo wax ku saabsan daawoyinka taageerida-nolosha** haddii aan si joogto ah miir daboolmo. Wakiilka daryeelkeyga caafimaadka waa in uu la shaqeyaa kooxda daryeelka caafimaadka si looga go'aamiyo haddii aan isticmaalayo daawoyinka taageerida-nolosha iyo haddii kale ee ku saleysan hadafyadeyda iyo heerarka. ***(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.)***

Magaca (Name) _____ Taariikhda (Date) _____

Ku deeqid Xubninta
(Organ Donation)

- Waxaan rabaa inaan ku deeqo indhaheyga, xuubka iyo/ama xunaha, haddii aan awoodo. Wakiilka daryeelka caafimaakeyga waxaa laga yabaa inu bilaabo iyo sii wado daaweynta baahan yahay ilaa ku deeqida laga dhammeystiro. *(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.)*
- Ma rabo inaan ku deeqo indhaheyga, xuubka iyo/ama xubnaha. *(I don't want to donate my eyes, tissues and/or organs.)*

Tilmaamaha Dheeraadka ah
(Additional instructions):

- Waxan ku lifaaqay # _____ bogga(yada) ee tilmaamaha dukumentigan.
(I have attached # _____ page(s) of additional instructions to this document.)

Ka dhigida Dukumentigaan Sharci
(Making this document legal)

1. Saxiixa iyo taariikhda (sign and date):

Saxiixeyga (My signature)

Taariikhda la Sixiay (Date signed)

2. Saxiixagaaga ma la xaqiijiyay ama 2 marqaati ma saxiixday. (Have your signature notarized OR verified by 2 witnesses)

MINNESOTA NOTARY PUBLIC
(NOOTAAAYADA DADWEYNAHA EE MINNESOTA):

NOTARY SEAL BELOW
(SHABADA NOOTAAAYADA HOOSE))

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.

Gobolka _____ (magaca gobolka)

Waxaan xaadir ahaa taariikhda _____ (taariikhda la cadeyey)

(qofka kor saxiixay)

Oganashaha saxiixdooda ee dukumentigan. Ma ihi wakiilka daryeelka
Caafimaadka dukumentigan.

Signature of Notary (Saxiixa Nooteyada) _____

Magaca (Name) _____ Taariikhda (Date) _____

AMA (OR)

CADEYNTA MARQAATIGA: Ugu yaraan waxaan jiraa 18 sano. Ma ihi wakiilka daryeelka caafimaadka ee ku magacaban dukumentigan. Hal marqaati oo kaliya wuxuu la shaqeyn kraa nidaamka daryeelka caafimaadka ee qof taariikhdaan.

(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.)

Saxiixa Marqaatiga #1 (Witness # 1 Signature) _____

Taariikhda la Saxiixay (Date Signed) _____

Qor Magaca (Printed Name) _____

Saxiixa # Marqaatiga #2 (Witness # 2 Signature) _____

Taariikhda la Saxiixay (Date Signed) _____

Qor Magaca (Printed Name) _____

