IT'S YOUR LIFE. IT'S YOUR CHOICE.

DYING WITH DIGNITY CANADA

MANITOBA

Health Care Directive

A. NOTES

A1 **"Health Care Directive" = Advance Directive**

A2 **To complete a Health Care Directive, you (the "Maker") must:**

- Be **16** years of age or older
- Have capacity to make health care decisions

A3 **"Proxy" = Substitute Decision-Maker**

A4 **A Proxy must:**

- Be **18** years of age or older
- Agree to be your Proxy
- Be apparently mentally competent

A5 **You do not need a witness if you are able to sign this Health Care Directive yourself.**

A6 **If you cannot complete and sign this Health Care Directive yourself, someone else can sign it for you. This must be done in your presence and the presence of a witness. This person cannot be your Proxy nor their spouse or common-law partner. This person can be your spouse or common-law partner, but this Health Care Directive will be revoked automatically upon divorce unless you indicate otherwise in the Health Care Directive.**

A7 **The witness must:**

- Be at least **18** years old
- **NOT** be the same person you chose as your Proxy, nor their spouse or common-law partner
- Sign the Health Care Directive in your presence

A8 **Amendments to The Health Care Directives Act allow for remote witnessing and signatures on behalf of the Maker using videoconferencing technology. There are important regulations in place for remote witnessing in Manitoba, and failure to follow the regulations may invalidate your Health Care Directive. You may consider seeking legal advice if you wish to proceed with this option. Learn more about the regulations at *canlii.ca/t/54vjm*.**

A9 **If you feel you have special circumstances that the Dying With Dignity Canada forms do not address, we suggest that you consult with a lawyer.**

B. PERSONAL INFORMATION

B1 **I,** _____ **revoke (cancel) any previous Health Care Directives made by me.**
(NAME)

B2 **Legal first name:** _____

B3 **Legal last name:** _____

B4 **Preferred name** (If different from legal name)**:** _____

B5 **Pronouns** (Optional)**:** _____

B6 **Date of birth:** _____

B7 **Address:** _____

B8 **Phone:** _____

B9 **Email:** _____

C. APPOINTING A PROXY
(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to make medical decisions for me if I do not have capacity to make health care decisions for myself:

PROXY #1

C2 **First name:** _____

C3 **Last name:** _____

C4 **Relationship to me:** _____

C5 **Address:** _____

C6 **Phone:** _____

C7 **Email:** _____

PROXY #2 (OPTIONAL)

C8 **First name:** _____

C9 **Last name:** _____

C10 **Relationship to me:** _____

C11 **Address:** _____

C12 **Phone:** _____

C13 **Email:** _____

NOTE: Only complete the next section if you choose more than one Proxy.

C14 **I want my Proxies to act:**

_____ (INITIAL) **Jointly** (They need to make decisions together)

_____ (INITIAL) **Consecutively** (The second Proxy will only make decisions if the first is unavailable)

C15 I authorize my Proxy/Proxies to make medical decisions on my behalf when I lack the capacity to do so for myself.

_____ (INITIAL) **With no restrictions**

_____ (INITIAL) **With the following restrictions** (please describe)

_____

_____

_____

_____

_____

_____

_____

_____

D. HEALTH CARE DIRECTIONS
(PLEASE READ EACH LINE CAREFULLY)

D1 _____ (INITIAL) **If I am sedated and unable to communicate, I would like the sedation lifted so that I can decide for myself to accept or refuse a particular therapy.**

D2 **Initial only ONE of the following two options. If you choose Option 1, skip to page 6.**

_____ (INITIAL) **Option 1:** I direct that my life be prolonged, and that I be provided **all life-sustaining treatments** that apply to my medical condition.

OR

_____ (INITIAL) **Option 2:** I direct that I **only receive care that will keep me comfortable and pain free**, and that my life is not prolonged (initial the options that apply below).

_____ (INITIAL) **In any circumstance**

_____ (INITIAL) **If I experience a serious life-threatening illness that cannot be reversed**

_____ (INITIAL) **If I experience permanent, chronic, and debilitating suffering**

_____ (INITIAL) **If I have advanced dementia** (please describe what this would look like for you)

_____

_____

_____

_____

_____ (INITIAL) **OTHER** (please explain)

_____

_____

_____

_____

_____

D3 **I specifically REFUSE (say no to) the following (initial where you refuse):**

_____ (INITIAL) **Electrical, mechanical, or other artificial stimulation of my heart** (such as CPR)

_____ (INITIAL) **Respirator or ventilator**

_____ (INITIAL) **Artificial feeding such as through a stomach tube, or an intravenous line** (IV)

_____ (INITIAL) **Being spoon fed, if I am no longer able to feed myself**

_____ (INITIAL) **Artificial hydration** (fluids) **by intravenous line**

_____ (INITIAL) **Antibiotics**

_____ (INITIAL) **Transfer to an intensive care unit or similar facility**

D4 **I would prefer to be cared for (select one):**

_____ (INITIAL) **At home**

_____ (INITIAL) **In hospice**

_____ (INITIAL) **In hospital**

D5 _____ (INITIAL) **If my health care provider will not follow this Health Care Directive, I ask that my care be transferred to another health care provider who will respect my legal rights.**

D6 _____ (INITIAL) **If I should be a patient in a health care facility which will not follow this Health Care Directive, I ask that I be transferred to another facility.**

ADDITIONAL DIRECTIONS:

MEDICAL ASSISTANCE IN DYING AND ADVANCE REQUESTS

D7 I understand that the current laws of Canada do not allow me to request medical assistance in dying (MAID) in advance. I understand that my Proxy cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Proxy and health care providers to act on my directions below.

E. SIGNATURES

MY SIGNATURE (THE "MAKER")

E1 **First name:** _____

E2 **Last name:** _____

E3 **Signature:** _____

E4 **Date:** _____

OR

SIGNATURE ON MY BEHALF (IN THE PRESENCE OF THE WITNESS BELOW)

E5 **First name:** _____

E6 **Last name:** _____

E7 **Relationship to the "Maker":** _____

E8 **Signature:** _____

E9 **Address:** _____

E10 **Phone:** _____

E11 **Email:** _____

E12 **Date:** _____

PROXY #1

I agree to be the Proxy for the person who created this Health Care Directive. I understand the responsibilities that come with this role.

E13 **First name:** _____

E14 **Last name:** _____

E15 **Signature:** _____

E16 **Date:** _____

PROXY #2 (OPTIONAL)

I agree to be the Proxy for the person who created this Health Care Directive. I understand the responsibilities that come with this role.

E17 **First name:** _____

E18 **Last name:** _____

E19 **Signature:** _____

E20 **Date:** _____

WITNESS (OPTIONAL – SEE NOTES ON PAGE 2)

I certify that I witnessed the signing of this Health Care Directive. I declare that I am not the Proxy nor the spouse or common-law partner of the Proxy.

E21 **First name:** _____

E22 **Last name:** _____

E23 **Signature:** _____

E24 **Address:** _____

E25 **Phone:** _____

E26 **Email:** _____

E27 **Date:** _____

F. DISTRIBUTION

I have shared this Health Care Directive with the following people. This is a reminder to me to keep these people informed of any changes. I am aware that outdated copies of my Health Care Directive may create confusion.

F1 **Name:** _____

F2 **Name:** _____

F3 **Name:** _____

F4 **Name:** _____

F5 **Name:** _____

F6 **Name:** _____

G. REVIEW

G1 You should review your Health Care Directive:

- At least every three years
- When your health situation changes
- When your Proxy/Proxies change(s)

_____ **Date of last review:** _____
(INITIAL)

_____ **Date of last review:** _____
(INITIAL)

_____ **Date of last review:** _____
(INITIAL)

_____ **Date of last review:** _____
(INITIAL)

H. NEXT STEPS

H1 **After completing your Health Care Directive, re-read it to ensure your preferences are clear.** Then, review it with your Proxy/Proxies. If a health care provider does not know you, they may need the Health Care Directive to understand your wishes for care.

H2 Keep a copy of your Health Care Directive in an easy-to-find place in an emergency. Leave a note in a prominent place, such as on your fridge with a magnet. This will let emergency personnel know where to look and who to call in a crisis. You can also print a wallet card and fridge note from the Dying With Dignity Canada website at ***dyingwithdignity.ca/advance-care-planning***.

H3 **Do not store your Health Care Directive in any locked box, drawer or safe.**

H4 Discuss your completed Health Care Directive with your health care provider. Give them a copy to put in your medical file. However, do not assume that doing so will result in your Health Care Directive being available in an emergency. You or your Proxy/Proxies must ensure health care providers are provided with a copy of your Health Care Directive. That is why you should appoint a Proxy.

H5 If there are no changes to be made, sign the Health Care Directive again with the new date.

H6 Your medical condition may change. Or you may reconsider some of the directions you wrote down. Download a new Health Care Directive at ***dyingwithdignity.ca/advance-care-planning*** or call Dying With Dignity Canada (DWDC) toll free at **1-800-495-6156** to receive a copy in the mail. Tell everyone involved in your care that you have updated your Health Care Directive.