



**Health Care Directive: Form** Note that this is the form for MANITOBA.

I revoke any previous Health Care Directives written by me.

Part 1: Appointing a Proxy (skip this section if you do not wish to appoint a Proxy)

I hereby designate the following person(s) as my Proxy:

(Appointing a proxy is highly recommended.)

PROXY 1

Name: **Husband's name and info** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

PROXY 2 (optional)

Name: **Daughter's name and info** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

I have named more than one Proxy: **Yes** No (circle one)

I wish them to act: **Consecutively** Jointly (circle one)

Part 2: Treatment Preferences

If the time comes when I lack the capacity to give directions for my health care, this statement shall stand as an expression of my wishes and directions.

1. In any of the following circumstances, I direct that I receive only such care as will keep me comfortable and pain free, and that my dying not be prolonged:

- a) An acute life-threatening illness of an irreversible nature
- b) Chronic debilitating suffering of a permanent nature
- c) Advanced dementia **(no longer able to recognize immediate family members)**
- d) **Permanent confinement in any institution**
- e) \_\_\_\_\_

2. In the circumstances set out in Section 1 above, I specifically refuse the following:

- a) Electrical, mechanical or other artificial stimulation of my heart
- b) Respirator or ventilator
- c) Artificial feeding e.g. G tube, NG tube, or central intravenous line
- d) Being fed should I no longer be able to feed myself
- e) Artificial hydration by intravenous line
- f) Antibiotics
- g) Transfer to an intensive care unit or similar facility
- h) **Any other drug, treatment, or surgical procedure, unless its primary purpose is comfort**
- i) \_\_\_\_\_

3. I specifically direct the following:

- a) Provide necessary medication to control my pain and control my symptoms even if such medication might shorten my remaining life
- b) Provide me with palliative care
- c) I would prefer to be cared for and to die at home **OR** **Whichever is more suited to my condition and easier for my family and caregivers**  
I would prefer to be cared for and to die in hospice
- d) **If I am unable to make my own decisions due to medication-related sedation, I would like the sedation lifted so that I can decide for myself whether to accept or refuse a particular therapy**
- e) \_\_\_\_\_

Section 4 note: If you **DO NOT WISH** to have your life prolonged under the conditions you have set down in Sections 1, 2 and 3, you must strike out Section 4 completely. If you **DO WISH** to have your life prolonged under any circumstances, and are requesting all treatment applicable to your medical condition, you must strike out Sections 1, 2 and 3 completely and leave only the directions you are giving under Section 4.

~~4. I specifically direct the following: I desire that my life be prolonged, and that I be provided all life-sustaining treatments applicable to my medical condition.~~

5. 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.

6. If I should be a patient in a hospital, or resident in a health care or long-term care facility which will not follow this Health Care Directive, I ask that I be transferred to another hospital or care facility.

**Section 7 note:** If you **DO NOT WISH** to provide directions regarding MAID, strike out this section. If you **DO WISH** to provide directions regarding MAID, write them below.

7. I understand that the current laws of Canada do not allow me to request medical assistance in dying (“MAID”) in advance, or for my SDM to consent to MAID on my behalf. However, if the law changes to allow my SDM and health care providers to act on my directions below, I wish for them to do so. Here are my directions regarding MAID: \_\_\_\_\_

**In any of the circumstances described in section 1, in addition to refusing the treatments listed in section 2, I wish for my life to end peacefully when I am no longer able to feed myself.**

**Once I stop eating or drinking, my death will be inevitable and reasonably foreseeable. At that point, I would want to receive Medical Assistance in Dying (MAiD) if possible (ie legal).**

**I am making this request now, in the hope that it will be legal before there is any need to act on it.**

Signature: Dorothy Stephens Originally Dated: date signed

Print Name: Dorothy Stephens

Reviewed on \_\_\_\_\_ Signature: \_\_\_\_\_

Reviewed on \_\_\_\_\_ Signature: \_\_\_\_\_

Reviewed on \_\_\_\_\_ Signature: \_\_\_\_\_

Review your HCD at least every 3 years.

If nothing has changed and you're still happy with it, just sign it again here with the new date.

**OPTIONAL:**

If you are unable to sign yourself, a substitute may sign on your behalf. The substitute must sign in your presence and in the presence of a witness. The Proxy or the Proxy's spouse cannot be the substitute or witness.

**No need for a substitute unless you are physically unable to**

Name of substitute: **write your name (eg due to disability or paralysis)** \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(A witness is not legally required in Manitoba but is highly recommended.)**

Name of witness: **Print name of witness** \_\_\_\_\_

Address: **(Your witness CANNOT legally be your proxy or your proxy's spouse, and should not be anyone who will inherit property or money from you)** \_\_\_\_\_

Signature: Witness's signature Date: \_\_\_\_\_

**Copies given to:**

- 1. Daughter's name**
- 2. Son's name**
- 3. Friend's name**

Make a note of who you give copies to. (You'd be surprised how quickly you'll forget.) That way, when you revise your HCD, you'll know who to collect the old versions from.