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

DYING WITH DIGNITY CANADA

MANITOBA

HEALTH CARE DIRECTIVE: Instructions

Read the Health Care Directive Form all the way through and do not start to fill in the form until you have read the directions on how to do so. Make sure you completely understand all the information and are satisfied that your Proxy understands that these are your wishes and is willing to act on your behalf. You will then be ready to complete your Health Care Directive Form and appoint your Proxy.

1. Read each line carefully and strike out any that do not apply to you or that you do not agree with. There are extra spaces for you to fill in any circumstances not covered – e.g. you may have a hereditary condition you want to address.

2. Please pay special attention to Section 4 in the Health Care Directive Form. If you **DO NOT WISH** to have your life prolonged under the conditions you have set out in Sections 1, 2 and 3 then 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, then you must strike out Sections 1, 2 and 3 completely and leave only the directions you are giving under Section 4.

3. Although in Manitoba you do not need a witness to your signature, we recommend that you have one. Anyone acting as a witness **CANNOT** be the proxy or the proxy's spouse.

4. **IF** you are physically unable to sign the Health Care Directive Form and you ask another person to sign on your behalf, this must be done in your presence with a witness who is not your Proxy. The person signing on your behalf or the spouse of the person signing on your behalf **CANNOT** act as your Proxy.

5. Make copies of the Health Care Directive Form before you sign and date, so that each copy has the original signatures.

6. Let your physician know that you have completed a Health Care Directive and offer them a copy for their own records. However, if they accept a copy, do not assume that it will be added to your hospital chart in the future when it is needed. Give a copy to whoever will be making decisions on your behalf if you cannot do so for yourself. Keep a copy where it can be easily found in an emergency situation. Leave a note in a prominent place – perhaps with a fridge magnet – saying where to find your Health Care Directive and who to call in an emergency. Do not store your Health Care Directive in a safety deposit box.

CHANGING YOUR MIND:

You can always change your mind. There is no requirement under Manitoba law that you update your signature. However, your Health Care Directive may not come into effect for a long time. Therefore, we advise that you review your Health Care Directive at least every three years. If there are no changes to be made, sign it again with the new date. There is space at the bottom of the form for you to do this. Keeping your Health Care Directive up-to-date helps ensure that your most current wishes will be reflected if you lose capacity to make health decisions.

If your medical condition has changed, or if you have reconsidered some of the answers you wrote down, ask us to send you a new form, and start over. Begin by revoking your previous Health Care Directive and continue on as before. Be sure to tell everyone involved in your care that you have revised your Health Care Directive.

Please note: If you feel you have special circumstances that the Dying With Dignity Canada forms do not address, we suggest that you consult with your lawyer.

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HEALTH CARE DIRECTIVE: Form

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:

PROXY 1

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (_____) _____

PROXY 2 (optional)

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (_____) _____

I have named more than one Proxy: ☐ Yes ☐ No

I wish them to act: ☐ Consecutively ☐ Jointly

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 (describe) _____

d) _____

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) _____

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

I would prefer to be cared for and to die in hospice OR

I would prefer to be cared for and to die in hospital

(You must choose only one option under 3c and strike out what does not apply)

d) _____

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: _____

_____

_____

_____

Signature: _____ Originally Dated: _____

Print Name: _____

Reviewed on _____ Signature: _____

Reviewed on _____ Signature: _____

Reviewed on _____ Signature: _____

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.

Name of substitute: _____

Address: _____

_____

Signature: _____ Date: _____

Name of witness: _____

Address: _____

_____

Signature: _____ Date: _____

I have distributed this Health Care Directive to the following people. This is a reminder to myself to keep these people informed of any changes. I am aware that outdated or defunct copies of this Health Care Directive may create confusion if left in circulation.

Name(s) and phone number(s):

_____

_____

_____

_____