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

COVID-19 Treatment Preferences

This document is only to be consulted by my health care agent and providers for treatment preferences if I contract COVID-19. These wishes do not replace or revoke my treatment preferences indicated in my existing health care directive for other medical circumstances.

I have initialed next to the statements I agree with:

Goal of Care

____ I would like all treatments that will prolong my life.

____ I would like skilled symptom management focused on reducing pain and discomfort, allowing a natural and comfortable death.

Location of Care

____ I prefer to receive intensive care at the hospital.

____ I prefer to be cared for at home.

____ I prefer to be cared for in a care facility. Name/Type: _____

Cardio-pulmonary Resuscitation (CPR)

If my heart stops:

____ I want CPR to be attempted.

____ I want CPR to be attempted unless my healthcare team agrees it will not be successful.

____ I do NOT want CPR to be attempted.

Mechanical Ventilation

____ I prefer to be sedated, intubated, and mechanically ventilated.

____ I prefer a time limited trial on a ventilator to determine whether my condition can improve: _____ days / weeks. (circle one)

____ I prefer not to be placed on a ventilator.

Name: _____ Date: _____

If I am on a ventilator:

____ If my healthcare team agrees there is a minimal chance for improvement or survival, I prefer mechanical ventilation to be stopped.

____ I prefer to be on a ventilator even if my long-term use of a ventilator requires a tracheostomy.

____ If my kidneys fail, I prefer to continue ventilation and receive dialysis.

Medications

____ If I experience difficulty breathing, I prefer to receive opioids to manage air hunger and be kept comfortable.

____ I prefer not to receive opioid medications.

____ I refuse opioid medications.

Palliative Care

____ I request palliative care consultation to recommend treatments and medications to manage any symptoms of discomfort and anxiety.

Hospice Care

____ If my healthcare team agrees there is minimal to no chance for improvement in my condition, I prefer that hospice care be initiated.

Comments/Notes:

It is important to have a conversation about your COVID-19 treatment preferences with your health care agent and/or healthcare provider. Please provide them with a copy of this document.

Name: _____ Date: _____