

How to Complete This Power of Attorney for Health Care

Overview

The attached Power of Attorney for Health Care form was developed to meet the legal requirements for Wisconsin.

This Power of Attorney for Health Care form allows you to appoint another person and alternate persons to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is your health care agent. This document gives your health care agent authority to make your decisions only when you have been determined by your physicians to be incapable of making your own health care decisions. It does not give your health care agent any authority to make your financial or other business decisions. In addition, it does not give your health care agent authority to make certain decisions about your mental health treatment.

Before completing this Power of Attorney for Health Care form, take time to read it carefully. **It is also very important that you discuss your views, values, and this document with your health care agent.** If you do not closely involve your health care agent and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future health care, but do not want to or cannot use this Power of Attorney for Health Care form, ask your health organization or attorney for advice about alternatives.

How to Complete This Document

This Power of Attorney for Health Care form is divided into four parts.

- Part I – Appointing a Person to Make My Health Care Decisions When I Can't Make My Own Health Care Decisions
- Part II – General Authority of the Health Care Agent
- Part III – Special Instructions
- Part IV – Making the Document Legal

Steps to Follow:

1. Carefully read and follow the instructions contained in each part of the attached document.
2. Provide the information on page 1.
3. Appoint one health care agent on page 4 and consider appointing at least one alternate.
4. Decide which choices, if any, you want to indicate on pages 6 & 7.
5. Consider including written instructions in Part III.
6. Sign and date the document on page 12 in the presence of two witnesses.
7. Have the document witnessed on page 13. Both witnesses must be present when you sign this document.

If you wish to donate your body after death to medical science, you should contact the medical school to which you wish to make the donation. Here are some places to contact in Wisconsin.

University of Wisconsin-Madison Medical School	(608) 262-2888
Medical College of Wisconsin	(414) 456-8261

After Completing This Document

After you complete the document, make copies to be given out as follows:

- Keep the original in a safe but accessible place.
- One copy for the health care agent and alternates appointed in the document.
- One copy to share and discuss with your physician.
- One copy for the hospital where you would go in an emergency.
- Extra copies to share with others if you wish (loved ones, your clergy, and your attorney).

A photo or fax copy is as legally valid as an original.

About Changing or Revoking This Document

If you wish to update your contact information or the contact information of your agent or alternate agent(s), attach a separate sheet of paper. Do not make these changes on the Power of Attorney for Health Care Document.

If you wish to change who you have selected as your agent or your alternate agent(s), you must complete a new Power of Attorney for Health Care document.

If you wish to revoke your Power of Attorney for Health Care document, you can do so by: completing a new document; destroying it; directing another person to destroy it in your presence; signing a written and dated statement; or stating that it is revoked in the presence of two witnesses. If you revoke your document, you should notify your agent, your health care providers and any other person to whom you have given a copy.

Power of Attorney for Health Care

for

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Copies of this document are being or have been given to:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

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Power of Attorney for Health Care Document

Notice to the Person Making This Document:

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY A PERSON WHO YOU WOULD WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU BECOME UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT, OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR LEGALLY SEPARATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID. YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE ANY ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR DOCUMENT OF GIFT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE IN THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

Part I – Appointing a Person to Make My Health Care Decisions When I Can’t Make My Own Health Care Decisions

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my health care agent. This person will make my health care decisions when I am determined to be incapable to make health care decisions as provided under state law.

Instructions for Completing This Part:

When selecting someone to be your health care agent, pick someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Make sure that you pick someone who will closely follow what you want and will be a good advocate for you. Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your agent and your alternate agent(s).

Your health care agent should be at least 18 years or older and should not be one of your health care providers or an employee of your health care provider or an employee of a health care facility in which you are a patient or reside, or a spouse of any of these providers or employees, unless they are a close relative. Space has been provided for a second and third alternate health care agent.

State law requires that this document become invalid if you have chosen your spouse as your agent and you later become divorced or have your marriage annulled. If this situation arises, be sure to consult your annulment/divorce attorney.

The person I choose as my Health Care Agent is:

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____ E-mail _____

Address: _____

City: _____ State: _____ ZIP code: _____

If this health care agent is unable or unwilling to make these choices for me, then my next choice for a health care agent is:

Second choice (Alternate Agent)

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____ E-mail _____

Address _____

City: _____ State: _____ ZIP code: _____

If this alternate health care agent is unable or unwilling to make these choices for me, then my next choice for a health care agent is:

Third choice (alternate agent)

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____ E-mail _____

Address _____

City: _____ State: _____ ZIP code: _____

Part II – General Authority of the Health Care Agent

I want my health care agent to do the following based on my most recent written or oral instructions. If I have not provided any written or oral instructions, my health care agent is to make decisions based on my best interests. (If you do not want your health care agent to do anything that is listed below you may include a limitation in Part III, the Special Instructions section.)

- To make choices for me about my health care, such as tests, medicine, and surgery. If treatment has already been started, my health care agent can keep it going or have it stopped.
- To interpret any instruction I have given according to my health care agent’s understanding of my wishes and values.
- To review and release my health records and personal files as needed for my medical care.
- To consent to and arrange for my health care in Wisconsin or any other state, as my health care agent thinks appropriate.
- To determine which health professionals and organizations provide my health treatment.
- To exercise the authority noted below in numbers 1, 2, 3 & 4 if I have so authorized.

I understand that my agent is prohibited by Wisconsin law from admitting me or committing me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the mentally retarded, a state treatment facility or a treatment facility. I also understand that my agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

Instructions for Completing These Sections:

Put your initials on the line (e.g. DJ) to indicate you have selected “yes”, “no” or “not applicable” in the next four sections. If you do not initial “yes”, your choice is considered to be “no.” This means only a court may make such a decision and not your health care agent.

1. Agent authority to admit me to a nursing home for long-term care:

_____ **Yes**, my health care agent has authority to admit me, if necessary, to a nursing home for long-term care, subject to any written or oral instructions I have given at any time.

_____ **No**, my health care agent does not have authority to admit me to a nursing home for long-term care. *If I initial “no,” or leave this section blank, I understand that I may still be admitted to a nursing home for long-term care but that a court order will be required to do so.*

2. Agent authority to admit me to a community-based residential facility for long-term care:

_____ **Yes**, my health care agent has authority to admit me, if necessary, to a community-based residential facility for long-term care, subject to any written or oral instructions I have given at any time.

_____ **No**, my health care agent does not have authority to admit me to a community-based residential facility for long-term care. *If I initial "no," or leave this section blank, I understand that I may still be admitted to a community-based residential facility for long-term care but that a court order will be required to do so.*

3. Agent authority to order the withholding or withdrawal of feeding tube:

_____ **Yes**, my health care agent has authority to have a feeding tube, which includes IV hydration, withheld or withdrawn from me subject to any written or oral instructions I have given. However, my agent may not do so if my physician has advised that, in his or her professional judgment, this will cause me pain or reduce my comfort.

_____ **No**, my health care agent does not have authority to have a feeding tube, which includes IV hydration, withheld or withdrawn from me. *If I initial "no," or leave this section blank, a feeding tube, which includes IV hydration, cannot be withheld or withdrawn from me in Wisconsin without a court order.*

4. Agent authority to make decisions if I am pregnant:

_____ **Yes**, my health care agent has authority to make decisions for me if my health care agent knows I am pregnant, subject to any written or oral instructions I have given.

_____ **No**, my health care agent does not have authority to make decisions for me if my health care agent knows that I am pregnant. *If I initial "no," or leave this section blank, health care decisions cannot be made for me during my pregnancy without a court order.*

_____ **Not applicable**, because I am either a male or no longer capable of becoming pregnant.

Part III –Special Instructions

My health care agent shall make health care decisions based on my most recent written or oral instructions. The following are instructions for my health care agent and/or physician providing my health care. If there are conflicts among my known values and goals, I want my agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, or my health care agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own health care.

Instructions for Completing This Part:

You are **not required** to provide any written instructions or make any selections in Part III. If you choose **not** to provide any written or oral instructions, your health care agent will make decisions based on what is considered your best interests.

If or when you have a serious illness or condition that will get worse over time, you will need to consider additional instructions specific to your illness or condition.

When completing these instructions, you may want to consider your views of Cardiopulmonary Resuscitation (CPR). CPR is a medical procedure that is designed to restore heart function and breathing when they have stopped. CPR is more successful in healthy persons who have a sudden injury or illness and less successful in persons who have an incurable illness that is getting worse over time. The complications of attempting CPR can include brain damage, broken ribs and the possibility that a natural death will be prolonged with increased suffering. It is important to talk with your health professional about whether attempting CPR makes sense for you especially if you have an incurable illness that may get worse over time.

If you do not want CPR attempted at any time, your physician should be made aware of this choice. Stating in this document that you do not want CPR attempted will not prevent emergency personnel from attempting CPR. You will need to also obtain a DNR (Do-Not-attempt-Resuscitation) bracelet/order from your physician to prevent emergency personal from attempting CPR if 911 emergency services are used.

If you want your doctor and health care agent to know any thoughts you have about CPR you can write them below in number 3 of this part III.

1. If I suffer a severe, permanent injury or disease of the brain:

(Put your initials (e.g. DJ) on the line next to one of the three choices. You may also provide oral instructions to your health care agent.)

If I reach a point where there is reasonable medical certainty that I will never recover my ability to know who I am, who my family and friends are, or where I am, I want to be kept comfortable and clean, but I want my health care agent to:

_____ stop or do not start medical treatments that might be used to prolong my life. Treatments I would not want if I were to reach this point include but are not limited to: feeding tubes including IV hydration, respirator/ventilator, CPR and antibiotics.

_____ continue or start feeding tubes including IV hydration if needed, but stop all other medical treatments including, but not limited to, a respirator/ventilator, CPR, and antibiotics.

_____ follow my instructions as provided in number 3 below.

2. Pain and Symptom Control:

[Put your initials (e.g. DJ) on the line to indicate your choice]

_____ If I reach a point where efforts to prolong my life are stopped, I want health care treatment and nursing care that will make me comfortable.

_____ I want my health care agent to follow my instructions as provided in number 3 below.

3. Other Instructions I Want My Health Care Agent to Follow:

4. If I am nearing my death, I want the following: (List the type of care, ceremonies, etc. that would make dying more meaningful for you.)

5. If it is possible, when I am nearing my death and cannot speak, I want my friends and family to know I have the following thoughts and feelings:

6. Persons I want my agent to include or exclude in the decision process:

I ask that my health care agent make reasonable attempts to include the following persons in my health care decisions if there is time: _____

_____.

I ask that my health care agent make reasonable attempts to exclude the following persons in my health care decisions: _____

_____.

7. Religion:

I am of the _____ faith, and am a member of the _____ Congregation, church,

synagogue, or worship group. Phone number of congregation, synagogue, or worship group

(if known): _____.

Please attempt to notify them.

8. Upon My Death:

(This portion of the document is optional. Whether or not you complete this portion, the remainder of the document is valid.)

After my death the following are my instructions. If my health care agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible. Failing to initial any of these lines creates no presumption about my desire to make or refuse to make an anatomical gift.

Autopsy:

(Initial both the first and second choice, or just one choice)

_____ I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future health care decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

_____ I do not want an autopsy performed on me, but understand an autopsy could be legally required.

Donation of My Organs or Tissue:

(Initial one.)

_____ I wish to donate only the following organs or parts if possible (name the specific organs or tissue):

_____.

_____ I wish to donate any organs or tissue if I am a candidate.

_____ I do not want to donate any organ or tissue.

Part IV – Making the Document Legal

Instructions for Completing This Part:

Locate two people to serve as witnesses who meet the qualifications listed below. Co-workers, neighbors or social workers employed by your health care provider are appropriate witnesses, as long as they meet the requirements listed below.

Do not sign and date this document unless your witnesses are present.

If you are unable to sign this document, you can select another person to complete Parts II and III of this document and to sign your name and date. This person should not be your agent, your alternate agent(s) or either of the witnesses. This person must sign in your presence and in the presence of the two witnesses.

I am thinking clearly. I agree with everything that is written in this document. I have made this document voluntarily.

My signature

Date

If I cannot sign my name, I can ask someone to sign this document for me. This person should not be my agent, my alternate agent(s) or either of the witnesses.

Signature of the person who I asked to sign this document for me

Print the name of the person who I asked to sign this document for me.

Statement of Witnesses

I know this person to be the individual identified in the document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not a health care agent or alternate health care agent appointed by the person signing this document.
- Not related to the person signing this document by blood, marriage or adoption.
- Not directly financially responsible for that person's health care.
- Not a health care provider serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a health care provider serving the person at this time.
- Not an employee (other than a social worker or chaplain) of an inpatient health care facility in which the person is a patient.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness number 1:

Signature Date

Print name

Address

Witness number 2:

Signature Date

Print name

Address