Honoring Choices
WISCONSIN
AN INITIATIVE OF THE WISCONSIN MEDICAL SOCIETY

Advance Directive

including Power of Attorney for Health Care

Overview

This legal document meets the requirements for Wisconsin, Minnesota and Iowa.* It lets you

- Name another person to make your health care decisions if you cannot make them for yourself.
- Write down your goals and preferences for future medical care in specific situations.

The person you name is called your health care agent. You can also name alternate health care agents who can make decisions if the person you named first or second cannot or is not willing to make those decisions. This document gives your agent authority to make health care decisions on your behalf only after doctors have determined you are incapable of making health care decisions for yourself.

This document **does not** give your agent authority to:

- Make financial or other business decisions.
- Make certain decisions about your mental health treatment.

Read this advance directive carefully before you complete and sign it. **You should discuss your goals, values, and this advance directive with your health care agent(s). Unless you talk with your health care agent(s), they may not know your goals and be able to follow your instructions.**

Recommendation: make an appointment with an advance care planning facilitator for help. If this advance directive does not meet your needs, ask your health organization or attorney about other options.

To complete this advance directive

This advance directive is divided into four parts:

Part 1 – My health care agent
Part 2 – General authority of the health care agent
Part 3 – Statement of desires, care instructions or limits
Part 4 – Making the document legal

Follow the instructions in each of the four parts.

After you complete your advance directive

Take these steps:

- Talk to the person(s) you named as your agent(s) about your goals and preferences for future medical care, if you have not already. Make sure they feel able to do this important job for you in the future.
- Give your agent(s) a copy of this advance directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your agent(s) is, and what your preferences are.
- Give a copy to your doctor and/or your health care facility. Make sure your preferences are understood.

*As of June 1, 2017

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- Keep a copy of this advance directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of this advance directive and ask that it be placed in your medical record.
- Review and update this advance directive whenever any of the "Five D's" occur:

  Decade – when you start each new decade of your life

  Death (or dispute) – when a loved one or a health care agent dies (or disagrees with your preferences).

  Divorce – when divorce (or annulment) happens. If your spouse or domestic partner is your agent, your advance directive is no longer valid. You must complete a new advance directive, even if you want your ex-spouse or ex-partner to remain your agent.

  Diagnosis – when you are diagnosed with a serious illness.

  Decline – when your health gets worse, especially when you are unable to live on your own.
- If your goals and preferences changed:
  - Talk to your agent(s), your family, your doctor, and everyone who has copies of this advance directive.
  - Then, complete a new advance directive.

Need help?

For help to complete this advance directive, contact:

Crossing Rivers Health
Patient Family Services
(608) 357-2000

Crossing Rivers Health
Your bridge to wellness

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For:

Name _____ Date of Birth _____

Telephone (Cell) _____ (Work) _____

(Home) _____

Address _____

City _____ State/ZIP _____

Copies of this document have been given to:

Name _____

Name _____

Name _____

Name _____

Name _____

Name _____

Name _____

Health care professional/health care facility:

Name _____

Name _____

Name _____

 June 2017

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Notice to 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 the person whom you want to make health care decisions for you if you are 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 or domestic partner and your marriage is annulled or you are divorced or the domestic partnership is terminated after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift that you may have made. You may revoke or change any anatomical gift that you make by 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 doctor.

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Part 1: My health care agent

If you can no longer make your own health care decisions, this advance directive names the person you authorize to make these choices for you. This person will be your health care agent. State law says he or she will make your health care choices for you only after doctors have determined you are incapable of making health care decisions. Your agent will make decisions about your medical care as you would if you were able. You and your health care agent(s) should have ongoing talks about your health and health care choices.

Choose someone who knows you well. It should be someone you trust and who respects your goals and values. This person should be able to make difficult decisions under stress. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Discuss this document and your views with the person(s) you choose to be your health care agent(s).

A health care agent must be at least 18 years old. Your health care agent may not be one of your health care providers or an employee of your health care provider, unless he or she is a relative.

The person I choose as my health care agent is:

Name _____ Relationship _____

Telephone (Cell)_____ (Work) _____ (Home) _____

Address _____

City _____ State/ZIP _____

If that person is unable or unwilling to make decisions for me, then my next choice is:

Second choice:

Name _____ Relationship _____

Telephone (Cell)_____ (Work) _____ (Home) _____

Address _____

City _____ State/ZIP _____

If that person is unable or unwilling to make decisions for me, then my next choice is:

Third choice:

Name _____ Relationship _____

Telephone (Cell)_____ (Work) _____ (Home) _____

Address _____

City _____ State/ZIP _____

☐ **I do not have a health care agent. Instead, I want Part 3 of this document to guide my health care.**

Part 2: General authority of the health care agent

To complete this part:

Draw a line through anything in the box below you do **not** want your health care agent to do. For example, it should look like this: ~~Decide on~~

I want my health care agent to be able to:

- Decide on tests, medicine, surgery and other medical care. If treatment has started, my agent can keep it going or stop it, based on my instructions or my best interests.
- Interpret my instructions based on what he or she knows of my preferences and values.
- Review and release my medical records and personal files as needed for my medical care.
- Arrange for my medical care and treatment in Wisconsin or any other state.
- Decide whether organs or tissues (anatomical gifts) can be donated after my death according to my preferences and values.

Limits on mental health treatment in Wisconsin

Wisconsin law says my health care agent may not admit or commit me to an inpatient facility for mental health treatment. This means that in Wisconsin, my agent cannot admit me to:

- an institution for mental diseases
- an intermediate care facility for people with an intellectual disability, or
- a state treatment facility for mental health.

My health care agent may not agree to any drastic mental health treatments for me. These treatments include experimental mental health research, brain surgery, or electroshock therapy.

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To complete the next three questions:

Initial or check the box beside the one statement in each section you agree with.
In Wisconsin, if you do not mark any box in a section, or you choose "no," only a court can make the decision and not your health care agent.

1. Agent authority to make the decision to admit me to a nursing home or community-based residential facility for long-term care.

Note: Your health care agent has the authority to admit you to a nursing home or care facility (community-based residential facility) for a **short-term** stay. For example, you might need care to recover after surgery and you expect to go home.

If I need **long-term** care for any reason, then:

☐ **Yes, my agent can make the decision** to admit me to a nursing home or community-based residential facility for a long-term stay.

☐ **No, my agent cannot make the decision** to admit me to a nursing home or community-based residential facility for a long-term stay.

In Wisconsin, choosing "no" or leaving this section blank means I cannot be admitted to a Wisconsin long-term care facility without a court order.

2. Agent authority to make the decision to refuse or have removed a feeding tube and/or IV fluids.

☐ **Yes, my agent can make the decision** to refuse or stop tube feedings and/or IV fluids.

☐ **No, my agent cannot make the decision** to refuse or stop tube feedings and/or IV fluids.

In Wisconsin, choosing "no" or leaving this section blank means feeding tubes and IV fluids cannot be refused or stopped without a court order.

3. Agent authority to make health care decisions during pregnancy.

☐ **Yes, my agent can** make health care decisions for me if I am pregnant.

☐ **No, my agent cannot** make health care decisions if I am pregnant.

☐ **This does not apply to me.**

In Wisconsin, choosing "no" or leaving this section blank means health care decisions cannot be made for me while I am pregnant without a court order.

Part 3: Statement of desires, care instructions or limits

Part 3 allows you to make your preferences clear. Your health care agent and your doctors will refer to this section as they care for you. If you did not name a health care agent or if your health care agent cannot be reached, you can direct your care with the choices you make below. You should talk with your health care agent about the kind of care you want, even if you don't make choices in this section.

You are not required to complete this part of the document.

To complete this part:

Initial or check the box beside the one statement you agree with.
You may add **other specific care instructions** on page 7.

1. Treatments that may prolong life if I am in this situation.

If I am sick or injured and my doctors believe there is little chance I will recover the ability to know who I am, who my family and friends are, or where I am, this is my choice:

☐ **I want to refuse or stop all treatments**. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, antibiotics, or fluids given to me through an IV, treatments for chronic medical conditions, or other medications.

☐ **I want to receive all treatments to keep me alive,** unless my doctor determines the treatments would harm me more than help me.

With either choice, I understand I will be kept clean and comfortable. I will continue to receive pain and comfort medicines, and food and fluids by mouth if I can swallow safely.

2. Cardiopulmonary resuscitation (CPR).

Based on my current health, this is my choice about CPR if my heart or breathing stops.

☐ I want CPR attempted ***unless*** my doctor determines:

- I have a medical condition and no reasonable chance of survival with CPR,
  OR
- CPR would harm me more than help me.

☐ I do not want CPR. Let me die a natural death.

If you do not want emergency personnel to give you CPR, you will need to talk to your doctor about other documents you need.

Specific care instructions to meet my goals and preferences in certain situations:

Comfort preferences: These things are important to me for comfort (for example, favorite music, warm blankets, best positioning in bed).

Including others when making decisions about my care: (If there is time, try to include these people in my care decisions.)

If I am near death and cannot communicate, I want to give my friends and family these personal messages:

If I am near death, things I would want: (For example, favorite music, rituals, dim lighting, a visit from the hospital chaplain or someone from my faith community.)

To complete this part:

Initial or check the box beside the statement you agree with.

After my death, these are some of my preferences:

1. Donation of my organs or tissue (anatomical gifts)

Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves.

☐ A. I do not wish to donate any part of my body.

☐ B. After I die, I wish to donate any parts of my body that may help others.*

☐ C. After I die, I wish to donate **only** these organs and tissue:* _____

_____

*If you checked B or C, register in your state at www.DonateLife.net to make your preferences legal.

2. Autopsy preference

Initial or check one box OR both B and C.

☐ A. I do not wish to have an autopsy.

☐ B. I would accept an autopsy if it can help my relatives and/or loved ones understand the cause of my death or if the findings may help them make their own health care choices.

☐ C. I would accept an autopsy if it can help advance medical knowledge or medical education.

Part 4: Making the document legal

In Wisconsin: This document must be signed and dated **in the presence of two witnesses** who meet the qualifications explained below. A notary public cannot be used instead of the two witnesses.

In Minnesota or Iowa: This document must be signed and dated **either in the presence of two witnesses** who meet the qualifications explained below **OR in the presence of a notary public**.

My signature and date

I am of sound mind. I agree with everything written in this document.
I have completed this document of my free will.

My signature _____ Date _____

If I cannot sign my name, I ask (print name) _____ to sign for me.

Signature of the person I asked to sign for me _____

Statement of witnesses

A. By signing this document as a witness, I certify I am:

- At least 18 years old.
- Not related by blood, marriage, domestic partnership, or adoption to the person signing this document.
- Not a health care agent appointed by the person signing this document.
- Not directly financially responsible for this person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee of a health care provider directly serving the person at this time.
  In Wisconsin, social workers and chaplains may serve as witnesses even if employed by the health care provider.
- Not aware that I am entitled to or have a claim against the person's estate.

B. I know this to be the person identified in the document. I believe this person to be of sound mind and at least 18 years old. I personally witnessed this person sign this document, and I believe that this person did so voluntarily.

Witness Number One:
Signature _____ Date _____

Print name _____

Address _____

City _____ State/ZIP _____

Witness Number Two:
Signature _____ Date _____

Print name _____

Address _____

City _____ State/ZIP _____

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Instructions for notarization (Minnesota or Iowa only)

Residents of Iowa and Minnesota may have the document signed and stamped by a notary public authorized in their state instead of two witnesses.

Notary Public:

In the state of Minnesota/Iowa (circle one), County of _____.

In my presence on _____ (date), _____ (name)

acknowledged his or her signature on this document or authorized the person signing this document to sign on his or her behalf. I am not named as a health care agent or alternate health care agent in this document.

_____ *Notary stamp (required):*
Signature of notary

_____
Title (and rank)

My commission expires (date): _____