A GIFT TO YOUR FAMILY

Planning Ahead for Future Health Needs

STATE BAR OF WISCONSIN
PINNACLE

A Gift to Your Family

Introduction

Who will make your medical decisions when you can't?

When you are no longer able to articulate your healthcare wishes, your family must make those decisions for you. If you have not discussed your desires with your family, these decisions become extremely difficult.

Making decisions about future medical care and sharing your wishes with your loved ones is truly *A Gift to Your Family*. Talking about your preferences for treatment will save your family the emotional burden of having to make decisions for you without knowing your wishes. Your family will feel reassured that they are respecting your wishes.

A Gift to Your Family is designed to help you get started with future health care planning. It includes Wisconsin state forms to help you put your decisions in writing after you have discussed them with your family. We encourage you to execute a Power of Attorney for Health Care or a Declaration to Physicians (Living Will) before a medical crisis occurs, and invite you to consider organ and tissue donation as you contemplate these important issues.

This guide helps answer basic questions about advance medical care planning. Your attorney, physician, and other health care professionals can answer more specific questions and, if necessary, help you complete the forms.

The time to plan ahead is now. *A Gift to Your Family* can help.

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Planning ahead for future health needs is truly **A Gift to Your Family.**

Important note: This consumer guide is now in its eight edition, and was reviewed for accuracy based on the laws in effect in February 2016. It is issued to inform, not to advise. This is not intended to be a substitute for legal, medical or other professional advice. Consult a trained expert for interpretation and application of current law.

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ADVANCE DIRECTIVES

"After my mother suffered a second stroke, her body was shutting down.

"The medical team was keeping her alive with feeding tubes in an unconscious state. Her Power of Attorney for Health Care indicated that she did not want feeding tubes, but I knew she would die without them.

"After much reflection, I honored her wishes, and she died. It would have been much harder to do so if we hadn't ever talked. But I knew I was doing what she would have wanted if she could have communicated for herself."

What are advance directives?

An advance directive is a written instruction that you make while you are mentally competent that states how you want your health care decisions to be made if you become incapacitated or cannot express your wishes. Advance directives guide your physician and other health care professionals, and relieve your family and friends from the burden of guessing what types of care and treatment you would want to receive. Wisconsin statutes recognize two forms of advance directives — the Power of Attorney for Health Care and the Declaration to Physicians (Living Will).

Power of Attorney for Health Care

This appoints an agent to make all health care decisions for you, in collaboration with your personal physician, if you lose the ability to make health care decisions for yourself. You also may complete a Power of Attorney for Health Care addendum, which includes a description of your treatment preferences and desires, in order to guide the agent. Your agent can tell the physician or hospital exactly what care you would want in all types of health decisions, not just those concerning life-sustaining treatment. In most cases, a court supervised guardianship and a protective placement proceeding can be avoided if a Power of Attorney for Health Care has been accurately completed.

Declaration to Physicians (Living Will)

This describes the kind of life-sustaining care you would want only if you had a terminal condition or were in a persistent vegetative state. The declaration directs your physician whether to withhold or withdraw life-sustaining treatment or a feeding tube if you develop an illness or injury that cannot be cured and your death is imminent. A Declaration to Physicians does not give authority to anyone to make health care decisions on your behalf. Therefore, if you must later go to a nursing home, a court supervised guardianship and protective placement proceeding will be required. This can be a costly process.

How do I get started?

For both the Declaration to Physicians and the Power of Attorney for Health Care, you may use the standard forms created by law. The forms and instructions are available in this guide, and at courthouses, hospitals, nursing homes, and through the Wisconsin Department of Health Services.

You must read the instructions carefully before completing either document. Completing the document incorrectly may invalidate it at the time when it is most needed. You may choose to have an attorney complete the standard forms or write an individualized document for you. Begin the process by thinking through your options and talking with your family. If you have specific legal or medical questions, consult your attorney, physician, or other health care professional.

Terminal Condition:
This is an incurable condition, caused by injury or illness, that will cause death in the near future, so that life-sustaining procedures only prolong the dying process.

Persistent Vegetative State:
This is an incurable condition in which one loses the ability to think, speak, and move purposefully but the heartbeat and breathing continue. Periods of sleep and wakefulness occur.

CPR and DNR (Do Not Resuscitate) Orders

When a person stops breathing and his or her heart stops beating, the term used is cardiopulmonary arrest. Cardiopulmonary resuscitation (CPR) is an emergency medical procedure used to try to restart the heartbeat and breathing.

CPR involves blowing into the mouth and pushing on the chest. Anyone trained in CPR can start this procedure. If done properly, CPR may lead to an adequate blood pressure that helps the vital organs (brain, heart, kidneys, and liver) survive. If this procedure does not revive the victim, the emergency team from the ambulance or the hospital will start Advanced Life Support (ALS). ALS includes placing a tube in the windpipe, using electrical shock applied to the chest and medications injected into the veins. The victim must then be transported to the hospital as soon as possible and may need a machine (ventilator) to breathe for him or her for an uncertain amount of time.

CPR is most effective when started immediately after a person passes out. If more than six minutes has passed before CPR is started, there is a strong possibility that serious vital organ damage has already occurred. Cold water drowning is the exception and can increase this time to as long as 40 minutes.

CPR is not always effective even when done properly. A victim who is elderly or has a serious medical condition such as emphysema, severe liver or kidney failure, or widespread cancer, has a low rate of survival.

CPR is not for everybody. Therefore, it is important for you to discuss this with your physician. If you sign a Power of Attorney for Health Care, you may add a statement indicating whether you would want CPR and under what circumstances.

A person may refuse CPR in an institutional setting such as a hospital or nursing home by having his or her physician write such an order. This order must be written, even if an advance directive has been completed, in order to notify all care providers. If this person has a cardiopulmonary arrest outside the hospital or nursing home, the emergency team will try to revive him or her unless he or she is wearing a Do Not Resuscitate (DNR) bracelet.

DNR Bracelets for Non-Hospitalized Patients

In 1996, the state legislature passed 1995 Wisconsin Act 200, which allows certain individuals to request a DNR bracelet. In 1999, the law was amended to allow the use of MedicAlert bracelets. In order to obtain a bracelet, a physician must sign the DNR order. A patient can receive a DNR bracelet order form from the Wisconsin Department of Health Services at (608) 266-1568 or from a physician's office*.

Who is eligible for a DNR bracelet?

The person must be at least age 18, not be pregnant, and have any of the following:

- A terminal medical condition;
- A medical condition that makes it unlikely that CPR will be successful (for example, severe disease of the heart, lungs, kidneys, or brain); or
- A medical condition that would make CPR cause more harm than benefit (for example, severe bone softening due to osteoporosis).

If the person qualifies, he or she may ask the attending physician for the bracelet. The person and the physician both must sign the order. The physician or the physician's representative then will place the bracelet on the person's wrist.

How do I revoke my DNR order?

The DNR order can be revoked easily by any of the following:

- Communicate your desire to revoke the DNR order to your family, agent or physician and promptly remove the bracelet;
- Deface, cut, burn or otherwise destroy the bracelet; or
- Remove the bracelet or ask another person to do so.

What may emergency responders do?

If you have a DNR order and bracelet, and emergency responders are called, they may (as appropriate):

- Clear airways;
- Administer oxygen;
- Position for comfort;
- Splint injured bones;
- Control bleeding;
- Provide pain medication;
- Provide emotional support; or
- Contact a hospice or home health agency if either has been involved in the patient's care.

If you have a DNR order and bracelet, and emergency responders are called, they may NOT:

- Perform chest compressions;
- Insert airways;
- Administer cardiac resuscitation drugs;
- Breathe for you; or
- Use electric shock to start your heart.

For more information, including a DNR Order Form, contact your physician or call the Wisconsin Department of Health Services at (608) 266-1568.

*WARNING: Only bracelets issued by a physician's order are legal in Wisconsin. Bracelets sold by a drug or discount store are not authorized by state law.

Commonly Asked **Questions**

Why should I have an advance directive?

An advance directive allows you to make your wishes clear to your family, friends, and health care professionals while you are still able to do so. It helps prevent disagreements among your family members about what treatment you should receive if you are incapacitated. The law does not allow a family member or others to make these decisions for you unless you are incapacitated and a specific family member is designated as your health care agent or is appointed by the court as your guardian.

What if I don't have an advance directive?

If you do not have an advance directive, and you are incapacitated, no one has legal authority to make your decisions. Your decisions might be left to your physician and a spouse, adult child, adult sibling, close friend or court-appointed guardian who has limited legal authority and may not know or carry out your wishes. If you have not designated a health care agent, loved ones may need to spend time and money seeking a guardianship in court in order to make decisions on your behalf.

When should I prepare an advance directive?

Now. While most people first think about preparing an advance directive when they are admitted to a hospital or nursing home, it is a good idea to think about doing so now – while your health permits you to do so.

Which document is right for me?

The Power of Attorney for Health Care may avoid costly guardianship proceedings in court; a Declaration to Physicians will not.

The Power of Attorney for Health Care is a more powerful and flexible document. A Power of Attorney for Health Care can include an addendum to specify treatment preferences. However, if you do not have someone to chose as your health care agent or your agent becomes incapacitated or dies, the Declaration to Physicians is your only option. If you have both a Declaration to Physicians and a Power of Attorney for Health Care, be sure they are consistent. If there is any conflict between the two, the Power of Attorney for Health Care will overrule the Declaration to Physicians.

What rights do I have regarding the medical care I receive?

As a competent adult, you have the right to make your own decisions about medical care, including accepting or refusing treatment.

Am I required to create an advance directive?

No. Federal law requires hospitals and other health care facilities to inform patients about advance directives when they are admitted, but health care providers cannot require you to have one.

What if I change my mind about my wishes?

Your Declaration to Physicians and your Power of Attorney for Health Care will last from the time they are created until your death, unless they are revoked or changed. They can be revoked or changed at any time if you do any of the following:

- Tear, burn, obliterate, or destroy the document or direct someone else to do so in your presence;
- Write and sign a cancellation;
- Verbally express your intent to cancel the document in the presence of two witnesses and notify your doctor of the revocation; or
- Write a new document.

Where should I keep my advance directive?

Keep one copy of your directive with your other important documents. Let your loved ones and your health care agent and alternate agent know that you have an advance directive, and give them a copy. You also may use a wallet card that indicates that you have an advance directive and where it can be found.

Be sure that one copy of your advance directive is included in your physician's medical record and at the hospital that would treat you. You may choose to carry your advance directive with you when you travel and keep it in the glove compartment of your car.

Where is my directive valid?

Your directive is valid in Wisconsin. If you spend considerable time in another state, you also should have one prepared in that state.

Incapacitated

This is defined by Wisconsin statute as the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions (Wis. Stat. § 155.01(8)).

Health Care Agent

This is someone you have chosen in your Power of Attorney for Health Care to make health care decisions for you if you are unable to express your own wishes for care or treatment. Your agent should have full knowledge of your wishes regarding future care and treatment.

Health Care **Agent**

ROLES AND RESPONSIBILITIES

Who can I appoint in my Power of Attorney for Health Care as my agent?

Your agent is usually a spouse, trusted relative, or friend. The agent must be at least age 18. You may choose any adult except for your health care provider (for example, physician or nurse), 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 your relative. You should be sure that the person you appoint is someone you trust and that you discuss with that person your treatment preferences, because that person will have authority to make important decisions on your behalf.

When does my agent assume responsibility?

Your agent will not make decisions on your behalf until or unless you lose the ability to do so. Two physicians or one physician and a psychologist must declare that you no longer have capacity. As soon as you have selected your agent, he or she needs to start learning about your values and wishes.

What does my agent need to know?

Your best protection in having your wishes honored is to communicate them effectively to your agent. For example, tell your agent how you feel about life support, being in a coma, and about the quality of life you hope to maintain. To facilitate the discussion, read through the Health Care Agent discussion points listed in this guide. Also, use the addendum to the Power of Attorney for Health Care to provide your agent with additional information.

What are my agent's responsibilities?

Your agent's main responsibility is to understand your beliefs and concerns about medical treatment. He or she also must be willing to make decisions that are consistent with your wishes, and communicate those wishes to your health care team. Your agent will need to talk regularly with your physicians and stay informed of your condition, treatment plan, and chances for recovery. Your agent must be certain that treatment matches your wishes. If the treatment does not, your agent must tell your physician or change physicians for you.

If I need a nursing home or community-based residential facility care, can my agent admit me?

Your health care agent can admit you to a nursing home or community-based residential facility (CBRF) for up to three months for respite or recuperative care, even if you have not checked "yes" on your Power of Attorney for Health Care. Your agent can do this without the need for guardianship or protective placement proceedings in court. In order for your agent to place you in a nursing home or CBRF for longer than three months, without court proceedings, you must check "yes" on your Power of Attorney for Health Care.

Does the person I appoint in my financial durable power of attorney automatically make my health care decisions?

No. The person you appoint as your agent in a durable power of attorney (generally relating to financial matters) is not granted the right to make health care decisions for you unless the document contains the essential language of the Power of Attorney for Health Care statute. It is common for people to appoint one agent for health care decisions and another agent to handle financial matters.

DISCUSSION POINTS

Issues for you to consider with your Health Care Agent

- ☐ Describe your current health status and your quality of life to your health care agent.
- ☐ Determine how important independence or self-sufficiency is to you. Discuss your general attitudes about illness, dying, and death.
- ☐ Think about whether your attitude about illness, dying, and death would be affected if your physical or mental abilities were decreased.
- ☐ Consider your feelings about using the following treatments, and how long you might want them tried and under what conditions (for example, mental status, odds of successful outcome):
  - Ventilator (respirator);
  - Artificial nutrition (through a tube in the nose or the abdomen);
  - Kidney dialysis;
  - Drugs to maintain heart rate and blood pressure; and
  - Attempting resuscitation (for example, chest compressions, artificial respiration, defibrillation).
- ☐ Think about the use of life-sustaining measures in the face of terminal illness, permanent coma, or irreversible chronic illness (for example, Alzheimer's disease).
- ☐ Determine what role your personal faith plays in your life and how these beliefs affect your attitude toward a serious or terminal illness and death.
- ☐ Discuss how your faith community views the role of prayer or religious sacraments in an illness.
- ☐ Think about what may be important to you as you are dying (for example, pain control, having family members present).
- ☐ Decide where you would prefer to die.
- ☐ Decide if you want to donate any parts of your body after you die (refer to Organ and Tissue Donation section).
- ☐ Tell your agent if you have discussed your wishes about end-of-life care with your physician.
- ☐ Think about whether you trust this person to carry out your wishes.
- ☐ Tell your agent if you have talked to your family about your wishes and if they are supportive.
- ☐ Tell your agent whom else you want involved in making decisions about your medical care.

Organ and Tissue Donations

Advances in medical technology over the last 30 years have allowed physicians to save lives, restore health, and improve the quality of life through organ and tissue donation. However, tens of thousands of individuals nationwide are on waiting lists for transplants. Every year, thousands of people die waiting for a donor to give them the gift of life.

If tragedy strikes, health care professionals will always try to save your life. Should all efforts completely fail, your organs and tissues may be eligible for donation. With no cost to you or your loved ones, you can give the gift of enhanced life or life itself. That is because your heart, kidneys, liver, lungs, corneas, and even your skin and bones can all be transplanted. In addition, donation is done within hours of death, so your family may proceed with funeral arrangements without delay or interruption.

Talk to your family about your decision to become a donor. It is important that those close to you know that you want to be a donor so that they will support your decision when the time comes for donation. It also is important that you talk to your physician about becoming a donor so that he or she can record your wishes in your medical record.

COMMONLY ASKED QUESTIONS

Why should I become an organ or tissue donor?

More than 2,000 people are on the donor waiting list in Wisconsin and many will die unless more donors participate. As just one person, you can give up to 50 people the gift of life or enhanced life if you become a donor.

How do I become an organ donor?

Sign the back of your driver's license or ID card, directly on top of the plastic. In addition, make sure that your Power of Attorney for Health Care indicates that you want to become a donor. The section is entitled "Anatomical Gifts." You also may fill out the donor card (on the back cover of this guide) to keep in your wallet. You can decide to donate any needed organ and tissue, or you can designate which organs and tissues you want to donate.

Most importantly, make sure that you share your decision to be a donor with your family and loved ones. Very often, a driver's license, donor card, or Power of Attorney for Health Care is not available at the time of death. When you make your wishes known, you relieve your family of the burden of needing to make the decision for you. A signed donor card and a family discussion will ensure that the decision made is the one you want.

Can I donate my body to medical research?

Yes, almost anyone can be considered a potential donor. You should talk to the medical school, research institute, or organ procurement organization in your area before designating your donation preferences because those entities may require specific documentation, completed prior to death, to make the donation valid. Occasionally, there are fees associated with body donation for medical education. The designation can be made on your driver's license or on the Anatomical Gift section of your Power of Attorney for Health Care.

When should I decide whether I want to be designated as a potential donor?

The time is now. Sign your driver's license and let your family know your decision.

Will age, health status, or poor eyesight make organ or tissue donation impossible?

Almost anyone can be considered a potential donor. Your age and medical history should not influence your decision to become a donor. Medical professionals carefully evaluate what organs or tissues are medically suitable for transplant.

Is there any cost involved for my family with organ and tissue donation?

No. The donation will be done at no financial cost to your family.

Will my preferences to become a donor affect my medical care or treatment?

No. Physicians and other health care professionals will always try to save your life. Donation becomes possible only after death is declared.

Is organ donation against my religion?

Most religious faiths support organ and tissue donation and many religious leaders nationwide strongly support donation because it brings life and health to another human being. You should talk to your clergy for peace of mind.

Before filling it out

Read the entire document carefully. Be sure you understand the authority you are giving to someone else. Think carefully about whom you want to select as your agent. You may not select your doctor, nurse, an employee of your health care facility, or spouse of any of these individuals, unless this individual is also a relative. Consider a close family member or friend — someone who knows you well, who lives geographically close to you, who will be a strong advocate for you and will ensure that your preferences are honored. Talk to that individual about your health care preferences, religious beliefs, and quality of life concerns. Ask the individual if he or she will accept this responsibility. Do the same with the individual you select as your alternate.

Filling it out

Do not insert the date at the bottom of the first page until the day you are ready to sign it. Print your name and address and date of birth after the "I" on the first page. In the next set of blanks, print the name, address and phone number (with area code) of the individual you have selected as your health care agent. If the individual is a relative, indicate the relationship in parentheses after the name. For example, "Jane Doe (daughter)." In the next blanks, print the name, address and phone number of the individual you have selected as alternate agent. Remember that you may only appoint one individual as your agent and one as your alternate.

Admission to nursing homes or community-based residential facilities

Decide whether you want your agent to have authority to admit you to a nursing home or community-based residential facility (group home). If you check "yes," your agent will be able to do so without going to court. That will save time, money, and some emotional anguish for you and your family. On the other hand, the court process is designed as protection for you, to ensure that you really need to be in a nursing home. Decide whether you are comfortable giving that power to your agent. If you check "no" or leave the question blank, your agent will not have that authority and a court proceeding will be required before you could be admitted to a nursing home, if you are not competent at the time.

Provision of feeding tube

Decide whether you want your agent to have authority to withhold or withdraw feeding tubes. If you check "yes," your agent will have the authority to decide, on a case-by-case basis, whether you would want him or her to withhold or withdraw these feeding tubes. If you check "no" or if you leave it blank, your agent would have to get a court order before being able to do so. (Important note: If you also complete the Declaration to Physicians, be sure that your two documents do not conflict. For example, if your Declaration to Physicians directs that feeding tubes be withheld, be sure to check "yes" on this question in your Power of Attorney for Health Care).

Health care decisions for pregnant women

This section applies only to women capable of becoming pregnant. If you are a man or a woman who is incapable of becoming pregnant, write "not applicable" next to the blanks. If you could become pregnant, decide whether you want your agent to have that authority. Keep in mind that there are decisions other than abortion that a health care agent might have to make. For example, if you are in a car accident while pregnant and left unconscious, someone has to decide whether to set broken bones. Even as to the abortion decision, you should consider checking "yes," but clarifying your position on abortion ("always," "never," "only in certain circumstances") in the next section. Again, if you check "no" or leave it blank, your agent will not have the authority to make decisions for you if you later become pregnant.

Statement of desires, special provisions or limitations

You are encouraged to add something to personalize the form. Print or type all inserts to ensure that they are legible. Consider adding some language indicating your beliefs about life support procedures, organ and tissue donations, organ and tissue transplants, autopsies, choice of health care provider or facility, or any preference to receive long-term care in your own home or in a nursing home. This also is the place to clarify, put limitations on, or further explain any of the earlier "yes" or "no" questions. For example, you could consider qualifying the nursing home admission by indicating a preference for home care over nursing homes or by indicating what decisions your agent can make if you later become pregnant. To further explain your preferences, you may want to consider creating an addendum to the Power of Attorney for Health Care. This addendum should be signed and witnessed like the document itself.

For the signing, you and your two witnesses must be together. A witness may not be (1) your agent, (2) a person with a claim on your estate, (3) a relative, (4) directly financially responsible for your health care, (5) your health care provider, (6) an employee of your health care provider, or (7) an employee of the health care facility in which you live. For (6) and (7), however, a person employed as a chaplain or social worker may be a witness. In the presence of the witnesses, you should sign and date the form. Have your two witnesses then sign, as indicated on the form. You should then ask your agent and alternate for their signatures. Insert your own name in the first two blanks under "Statement of Health Care Agent" and "Alternate Health Care Agent" and your agent and alternate are then ready to sign. (Note: If your agent or alternate live elsewhere, you may mail the document to them for their signatures. No witnesses are required.)

After it is completed

Make several copies of the form. Give the original to your physician (if you have a regular attending physician, as opposed to a clinic) and discuss with him or her your choice of agent, as well as your health care preferences, as indicated on the form. Ask your physician to honor your preferences and respect your choice of agent, if the situation ever arises. Give copies of the completed form to your agent and your alternate agent. Put one copy in a safe place at home and send one copy to the hospital that would treat you. You may want to keep a copy in the glove compartment of your car if you travel. You also may, for a small fee, file a copy with the Register-in-Probate in your county's probate court office. Discuss with close family members your choice of agent and your health care preferences. Ask them, too, to respect your choice of agent and your decisions and to honor those decisions, if the situation ever arises. Complete the wallet card (on the back of this guide) and put it in your wallet.

POWER OF ATTORNEY FOR HEALTH CARE

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, health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner and your marriage is annulled or you are divorced or your 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 physician.

POWER OF ATTORNEY FOR HEALTH CARE

Document made this _____ day of _____ (month),_____ (year).

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, _____

_____

_____

(print name, address, and date of birth), being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate

_____

_____

(print name, address and telephone number) to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate

_____

_____

(print name, address and telephone number) to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient, or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

POWER OF ATTORNEY FOR HEALTH CARE

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the persons with an intellectual disability, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

1. A nursing home — ☐ Yes ☐ No

2. A community-based residential facility — ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may admit me only for short-term stays for recuperative care or respite care.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube — ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withdrawn from me.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant — ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions or limitations that I wish to state (add more items if needed):

1._____

2. _____

3. _____

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

(a) Request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.

(b) Execute on my behalf any documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(The principal and the witnesses all must sign the document at the same time.)

SIGNATURE OF PRINCIPAL

(Person creating the Power of Attorney for Health Care)

Signature_____Date _____

(The signing of this document by the principal revokes all previous powers of attorney for health care documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, domestic partnership, or adoption, and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time; an employee of the health care provider, other than a chaplain or a social worker; or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness Number 1

(Print) Name_____Date _____

Address_____

Signature_____

Witness Number 2

(Print) Name_____Date _____

Address_____

Signature_____

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that _____
(name of principal) has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and is unable to make health care decisions himself or herself.

_____ (name of principal) has discussed his or her desires regarding health care decisions with me.

Agent's Signature_____

Address_____

Alternate's Signature _____

Address_____

Failure to execute a power of attorney for health care document under chapter 155 of the Wisconsin Statutes creates no presumption about the intent of any individual with regard to his or her health care decisions.

This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.

ANATOMICAL GIFTS (optional)

Upon my death:

- ☐ I wish to donate only the following organs or parts: (specify the organs or parts).

  _____

  _____

  _____

- ☐ I wish to donate any needed organ or part.
- ☐ I wish to donate my body for anatomical study if needed.
- ☐ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failing to check any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

NOTE: Checking a box above is informative only. To make your wishes legally effective, register to donate at www.donorregistry.wisconsin.gov.

Signature_____Date _____

OPTIONAL - ADDENDUM TO THE POWER OF ATTORNEY FOR HEALTH CARE

If I am in a terminal condition, a persistent vegetative state, or have advanced dementia or other similar mental incapacity or have a permanent disability that prevents me from communicating my wishes, I direct my Power of Attorney for Health Care to carry out my wishes. My wishes include:

Agree	Disagree	
☐	☐	Request that my physician issue a Do Not Resuscitate (DNR) Order
☐	☐	Do not use feeding tubes, including stomach tubes, nasogastric tubes, which are placed down the nose, or intravenous feedings, except to increase my comfort or reduce my pain.
☐	☐	Do not transport me to the hospital for treatment of any condition except to increase my comfort or reduce my pain.
☐	☐	Do not perform any surgical procedures, except to increase my comfort or reduce my pain.
☐	☐	Do not use antibiotics or provide immunizations, except to increase my comfort or reduce my pain.
☐	☐	Do not do any testing which may cause me any distress, except to increase my comfort or reduce my pain.
☐	☐	Do not do any radiation or chemotherapy, except to increase my comfort or reduce my pain.
☐	☐	Do not use any resuscitation or advanced life support. This includes machines to help breathing or medications to maintain the heart and blood pressure.
☐	☐	Do not do kidney dialysis, either peritoneal or hemodialysis.
☐	☐	Err on the side of over-medication rather than under-medication for pain, even if taking such may result in my death. For me, the goal of pain management is total relief of pain regardless of the risks.
☐	☐	Be an active advocate as my Power of Attorney for Health Care. Do not simply give in to decisions that physicians make. Ask questions and understand proposals, challenge assumptions and be prepared to say no to care which I would not want and to demand care that I would want.
☐	☐	Remember that I want to be an organ and tissue donor. If the requirements for organ donation conflict with my wishes above, I direct that such actions be taken so as to preserve organ function and permit organ donation to occur.

Important considerations for my future care: _____

_____

Other thoughts: _____

_____

Signature of Principal _____ Date _____

Signature of Witness Number 1 _____ Date _____

Signature of Witness Number 2_____ Date _____

As used in this Addendum, I intend that the following terms have the following meanings:

Terminal Condition: This is an incurable condition, caused by injury or illness, that will cause death in the near future, so that life-sustaining procedures only prolong the dying process.

Persistent Vegetative State: This is an incurable condition in which one loses the ability to think, speak and move purposefully but the heartbeat and breathing continue. Periods of sleep and wakefulness occur.

Advanced Dementia/Senility: This is severe incurable, progressive brain damage caused by strokes, injury, infection or Alzheimer's Disease, that leads to the loss of the ability to communicate with people, to recognize family and friends, and to provide for one's needs.

Instructions—Declaration to Physicians (Living Will)

Before filling it out

Read the entire document carefully. Be sure you understand what it means and that you are comfortable with its language. Also, if you are or have already completed a Power of Attorney for Health Care, consider whether you need this document. The issues in the Declaration to Physicians also could be addressed in your Power of Attorney for Health Care. If you determine you do need or want this document, proceed.

Filling it out

Print your name in the first blank and then proceed to the check-offs. Paragraph two addresses the question of use of feeding tubes if you have a terminal condition. Paragraph three addresses first the question of life-sustaining procedures and then, separately, feeding tubes, if you are in a persistent vegetative state.

You are now ready for the signing. You and your two witnesses must be together. The witnesses must be at least 18, not be relatives by blood or marriage nor an employee of your health care provider or your health care provider's spouse. (Exception: Social workers and chaplains may witness these documents.) If you are physically unable to sign a declaration, the declaration must be signed in your name by one of the witnesses or some other person at your express direction and in your presence; such a proxy signing must either take place or be acknowledged by you in the presence of two witnesses. Valid witnesses acting in good faith are immune from civil or criminal liability.

After it is completed

Make several copies of the form. Give the original to your physician (if you have a regular physician, as opposed to a clinic), discuss your choices, and ask him or her to honor them if the situations ever arise. You are responsible for notifying your attending physician of the existence of the declaration. An attending physician who is notified must make the declaration part of your medical records. A declaration that is in its original form or is a legible photocopy or electronic facsimile copy is presumed to be valid. Discuss and consider giving copies of the document to family members and ask them, too, to honor your choices, as indicated on the form. Put one copy in a safe place at home (not in a locked bank box) and give a copy to the hospital that would treat you. You may want to keep a copy in the glove compartment of your car if you travel. You also may, for a small fee, file a copy with the Register- in-Probate in your county's probate court office.

Complete the wallet card (on the back of this guide) and put it in your wallet.

Definitions

Declaration – A written, witnessed document voluntarily executed by the declarant under Wis. Stat. § 154.03(1), but is not limited in form or substance to that provided in Wis. Stat. § 154.03(2).

Department – Department of Health Services.

Feeding tube – A medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth, or other body opening of a qualified patient.

Terminal condition – An incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

Persistent vegetative state – A condition that reasonable medical judgment finds constitutes complete and irreversible loss of all the functions of the cerebral cortex and results in a complete, chronic, and irreversible cessation of all cognitive functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue.

Qualified patient – A declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by two physicians, one of whom is the attending physician, who have personally examined the declarant.

Attending physician – A physician licensed under Wis. Stat. chapter 448 who has primary responsibility for the treatment and care of the patient.

Health care professional – A person licensed, certified or registered under Wis. Stat. chapters 441, 448 or 455.

Inpatient health care facility – Has the meaning provided under Wis. Stat. § 50.135(1) and includes community-based residential facilities as defined in Wis. Stat. § 50.01(1g).

Life-sustaining procedure – Any medical procedure or intervention that, in the judgment of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient. "Life-sustaining procedure" includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis, and other similar procedures, but does not include (a) the alleviation of pain by administering medication or by performing an medical procedure; or (b) the provision of nutrition or hydration.

PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT
BEFORE YOU COMPLETE AND SIGN IT

DECLARATION TO PHYSICIANS (WISCONSIN LIVING WILL)

I, _____

being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a TERMINAL CONDITION, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

   ☐ YES, I want feeding tubes used if I have a terminal condition.

   ☐ NO, I do not want feeding tubes used if I have a terminal condition.

   If you have not checked either box, feeding tubes will be used.

2. If I am in a PERSISTENT VEGETATIVE STATE, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures:

   ☐ YES, I want life-sustaining procedures used if I am in a persistent vegetative state.

   ☐ NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

   If you have not checked either box, life-sustaining procedures will be used.

3. If I am in a PERSISTENT VEGETATIVE STATE, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of feeding tubes:

   ☐ YES, I want feeding tubes used if I am in a persistent vegetative state.

   ☐ NO, I do not want feeding tubes used if I am in a persistent vegetative state.

   If you have not checked either box, feeding tubes will be used.

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

DECLARATION TO PHYSICIANS (WISCONSIN LIVING WILL)

ATTENTION: You and the 2 witnesses must sign the document at the same time.

Signed _____ Date _____

Address _____ Date of Birth _____

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness Signature _____ Date Signed _____

Print Name _____

Witness Signature _____ Date Signed _____

Print Name _____

DIRECTIVES TO ATTENDING PHYSICIAN

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when 2 physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.
2. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.
3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.
4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

* * * * *

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

_____

_____

_____

RESOURCES LIST

For more information on HEALTH CARE PLANNING, contact:

Alzheimer's Association
of Southeastern Wisconsin
620 South 76th Street
Suite 200
Milwaukee, WI 53214-3254
(414) 479-8800
(800) 272-3900
www.alz.org/sewi

Center for Bioethics and
Medical Humanities
Medical College of Wisconsin
8701 Watertown Plank Road
Milwaukee, WI 53226
(414) 955-8498
www.mcw.edu/bioethics

Greater Wisconsin Agency
for Aging Resources
1414 MacArthur Road, Suite A
Madison, WI 53714
(608) 243 5670
Fax: (866) 813-0974
www.gwaar.org

State Bar of Wisconsin
5302 Eastpark Blvd.
P.O. Box 7158
Madison, WI 53707-7158
(800) 728-7788
www.wisbar.org

Wisconsin Medical Society
330 E. Lakeside Street
Madison, WI 53715
(866) 442-3800 (toll-free)
Fax: (608) 442-3802
www.
wisconsinmedicalsociety.org

Wisconsin Hospital
Association
5510 Research Park Drive
Madison, WI 53711
(608) 274-1820
Fax: (608) 274-8554
www.wha.org

Wisconsin Department of
Health Services
Division of Public Health
1 W. Wilson Street
Madison, WI 53703
(608) 266-1865

For more information on ORGAN AND TISSUE DONATION, contact:

Allograft Resources, Inc.
3553 University Ave.
Madison, WI 53705
(608) 231-9050

Lions Eye Bank of
Wisconsin, Inc.
2401 American Lane
Madison, WI 53704
(877) 233-2354 toll-free
(608) 233-2354
Fax: (608) 233-2895
www.lebw.org

National Kidney Foundation of
Wisconsin
10909 W. Greenfield Ave., Suite 201
West Allis, WI 53214
(414) 897-8669
Fax: (414) 930-0337
www.kidneywi.org

University of Wisconsin Hospital
and Clinics - Organ and Tissue
Donation
600 Highland Avenue
Madison, WI 53792
(608) 265-0356
www.uwhealth.org/organ-donation/

Wisconsin Donor Network
638 N. 18th St.
Milwaukee, WI 58233
(414) 937-6999
(800) 722-8230
www.bcw.edu

Wisconsin Tissue Bank
638 N. 18th St.
Milwaukee, WI 53233
(414) 937-6999
(800) 722-8230

For more information on DONATING YOUR BODY TO SCIENCE, contact:

Medical College of Wisconsin
Anatomical Gifts Registry
8701 Watertown Plank Rd.
Milwaukee, WI 53226
(414) 955-8261
www.mcw.edu/Anatomical-
Gift-Registry.htm

University of Wisconsin School of
Medicine and Public Health Body
Donation Program
1300 University Ave.
Madison, WI 53706
(608) 265-3295
ww.bdp.wisc.edu

MY ALTERNATE AGENT IS:

Name: _____

Address: _____

Phone: Home ( ) _____ Work ( ) _____

MY PHYSICIAN IS:

Name: _____

Address: _____

Phone: _____

Date: _____

IN CASE OF **EMERGENCY**

MY ALTERNATE AGENT IS:

Name: _____

Address: _____

Phone: Home ( ) _____ Work ( ) _____

MY PHYSICIAN IS:

Name: _____

Address: _____

Phone: _____

Date: _____

IN CASE OF **EMERGENCY**

IN CASE OF **EMERGENCY**

I HAVE AN ADVANCE DIRECTIVE

My Name: _____

Address: _____

Phone: _____

MY ADVANCE DIrective is filed at:

Location: _____

Address: _____

Phone: _____

MY HEALTH CARE AGENT IS:

Name: _____

Address: _____

Phone: Home ( ) _____ Work ( ) _____

UNIFORM DONOR CARD

I, _____

upon my death wish to donate:

☐ any needed organs and tissues
☐ only the following organs and tissues

Donor Signature:_____

Date: _____

IN CASE OF **EMERGENCY**

I HAVE AN ADVANCE DIRECTIVE

My Name: _____

Address: _____

Phone: _____

MY ADVANCE DIrective is filed at:

Location: _____

Address: _____

Phone: _____

MY HEALTH CARE AGENT IS:

Name: _____

Address: _____

Phone: Home ( ) _____ Work ( ) _____

UNIFORM DONOR CARD

I, _____

upon my death wish to donate:

☐ any needed organs and tissues
☐ only the following organs and tissues

Donor Signature:_____

Date: _____

Where can I purchase additional copies of *A Gift to Your Family* consumer guide?

State Bar of Wisconsin
(800) 728-7788
www.wisbar.org

Sponsored by _____

STATE BAR OF WISCONSIN

This consumer guide provided courtesy of: