



# Advance Directive including Power of Attorney for Healthcare

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Person for who document is prepared)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

**Please file these documents with your Primary Care Provider  
and your health system through the options below:**

Hand deliver to the clinic  
Fax to: 920-766-4659

Mail to: Kaukauna Clinic, S.C.  
Attn: Patient Services  
305 East 12<sup>th</sup> Street  
Kaukauna WI 54130

**Please give copies to all your healthcare agents listed in your Advance Directive.  
In addition to Healthcare agents, copies of this document have been given to:**

\_\_\_\_\_

## How to Change Demographic Information for You or Your Agent

Edits to this document (other than change of address and phone number for you or your healthcare agents) require an entirely NEW document. Crossing out or whiting out nullifies the Advance Directive. To provide a change of address/phone number for an existing Advance Directive, complete the Name and Date of Birth lines above; provide the new address/phone number information below and submit to your primary care physician.

**The change of address pertains to:** \_\_\_\_ Principal  
(Person for who Advance Directive is created)  
\_\_\_\_ Healthcare Agent

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# How to Complete This Power of Attorney for Health Care

## Overview

The attached Power of Attorney for Health Care form is a legal document developed to meet the legal requirements for the State of Wisconsin. It may not satisfy the legal requirements in other states. This Power of Attorney for Health Care form allows you to appoint another person to make 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 health care decisions on your behalf only when you have been determined by your physician(s) to be incapable of making your own health care decisions. This document 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 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, your views and values may not be fully respected because they will not be understood.

## Steps to Complete This Document

1. Please complete this document in **black ink only** so it can be read on the electronic health record.
2. Carefully read and follow instructions for each part.
3. Complete the information on page 1.
4. Part I---Appointing a Health Care Agent—Complete by appointing and listing information about at least one person who will act as your health care agent.
5. Part II---General Authority of the Health Care Agent—Complete by indicating your choices.
6. Part III---Making the Document Legal
  - Sign and date the document on page 10 with witnesses present;
  - Have the witnesses sign the document in your presence.
7. Part IV---Statement of Desires—Complete by indicating any special instructions or desires.

## After Completing This Document

After you complete the document, it is suggested that you:

1. Keep the original in a safe place that you can access easily;
2. Make copies to be given out as follows:
  - one copy for each health care agent appointed in the document;
  - one copy for your record at your physician's office;
  - one copy for you to provide to any hospital to which you are admitted or go for emergency treatment;
  - extra copies to share with others if you wish (loved ones, your minister/clergy/rabbi, and your attorney).

A photo or fax copy or copy in your electronic medical record is as legally valid as an original.

## **Power of Attorney for Health Care Document**

### **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 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.

Keep this page with your completed Power of Attorney for Health Care document.

## Part I – Appointing a person to make my health care decisions when I cannot 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 Wisconsin law. I understand that it is important for my health care agent and me to have ongoing discussions about my health and health care choices.

### ***Instructions for Completing Part I:***

When selecting someone to be your health care agent, choose 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. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person you choose to be your health care agent.

Your health care agent should be at least 18 years old and must not be one of your health care providers or an employee (or the spouse of an employee) of your health care provider or facility unless they are a close relative. Space has been provided for a second and third alternate health care agent.

#### **The person I choose as my health care agent is:**

Name: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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:**

Name: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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:**

#### **Third choice:**

Name: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## **Part II – General Authority of the Health Care Agent**

Unless I have specified otherwise in this document, I want my health care agent to be able to do the following:

- To make choices for me about my medical care or services, e.g., tests, medicine, and surgery, in accordance with my stated instructions or desires and/or my philosophy regarding the health care decisions I would make if I were able;
- To interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values;
- To make choices for me based on what my health care agent believes to be in my best interest if I have not expressed a health care choice about the health care in question and communication cannot be made with me;
- To review and release my medical records and personal files as needed for my medical care;
- To move me to another state if needed; and
- To determine which health care professionals and organizations provide my medical treatment.

If none of the Health care Agent(s) appointed by me in this document is available after reasonable attempts have been made to contact my Health care Agent(s), then I request:

- my healthcare providers,
- any later-appointed guardian, and/or
- those close to me

to follow the principles and instruction expressed in this Power of Attorney for Healthcare or in any other Advance Directive (Living Will) document I may have signed, to the extent permitted by law.

### **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 mental retardation, 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.

## ***Instructions for Completing Part II:***

Initial applicable boxes in the following six sections:

Due to limits in Wisconsin law, if you do not initial any box in a section, your health care agent may not have the authority to make the decision about the treatment discussed in sections 1 through 7. It may be necessary to go to court to obtain a decision about your treatment.

### **1. Admission to Nursing Homes or Community-Based Residential Facilities:**

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

**Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care.**

*(Initial one box.) Additional Guidance may be added at no. 7.*

Yes, my health care agent has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay subject to any limits I have set forth in this document.

*or*

No, my health care agent does not have authority to admit me to a nursing home or a community-based residential facility for a long-term stay. If I check "no," I cannot be admitted to a nursing home or community-based residential facility for purposes of a long-term stay *without court involvement*.

### **2. Withholding or withdrawal of feeding tube:**

*(Initial one box.) Additional Guidance may be added at no. 7.*

Yes, my health care agent has authority to have a feeding tube withheld or withdrawn from me, unless my attending physician advises that, in his or her professional judgment, the withholding or withdrawing will cause me pain or reduced comfort.

*or*

No, my health care agent does not have authority to have a feeding tube withheld or withdrawn from me. I am aware that if I check no, court involvement may be required for decisions to withhold or withdraw a feeding tube.

Under Wisconsin law, my health care agent may not consent to the withholding or withdrawal of *orally* ingested nutrition or hydration unless the provision of such nutrition or hydration is medically contraindicated.

### 3. Decisions During Pregnancy:

(Initial one box.) Additional Guidance may be added at no. 7.

- Yes, my health care agent has authority to make decisions for me if I am pregnant subject to any limits I have later set forth in this document.
- No, my health care agent does not have authority to make decisions for me if I am pregnant. I am aware that if I check no, court involvement may be required for health care decision making during my pregnancy.
- Not Applicable.

### 4. Preferences Regarding Attempts at Life Prolonging Treatments:

(Initial the box if it applies.) Additional Guidance may be added at no. 7.

I have considered the benefits and burdens of continued treatment in the event of prolonged suffering, terminal illness, or irreversible diagnoses, or in the event that it is reasonably certain that I will not recover from my condition:

I want **to stop or withhold all treatments** that might be used to prolong my dying. This includes, but is not limited to, respirator/ventilator (breathing machine), administration of blood products and antibiotics, medications and interventions that I have received for chronic medical conditions, or other medications unless the withholding or withdrawal of these treatments would cause me pain or discomfort.

or

I **do want** all appropriate treatments recommended by my doctor, until my doctor and agent agree that such treatments are harmful or no longer beneficial.  
*With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and fluids by mouth if I am able to swallow safely.*

*With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and fluids by mouth if I am able to swallow safely.*

## 5. Cardiopulmonary Resuscitation (CPR):

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube. I understand that CPR may save my life. I also understand that it does not work as well for people who have chronic (long-term) diseases and/or impaired functioning. I understand that if I do not want CPR attempted and prefer to allow a natural death; my physician should be made aware of this choice. Therefore:

(Initial one box.) Additional Guidance may be added at no. 7.

I want Cardiopulmonary Resuscitation (CPR) attempted **unless** my physician determines one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long term survival if my heart stops and the process of resuscitation would cause significant suffering.

or

I do not want CPR attempted if my heart stops, but rather want to allow a natural death to occur.

With either choice, I will need to obtain a *DNR Bracelet* from my physician if I have a terminal illness and do not want emergency personnel to perform CPR.

## 6. Implantable Cardiac Devices (if applicable)

Implantable cardiac devices, like pacemakers or defibrillators, are effective in bypassing life-threatening electrical abnormalities of the heart and treating potentially fatal abnormal heart rhythms. Devices can always be turned off, or even removed. It is important to talk with your primary physician, cardiologist and/or electrophysiologist about your decision to continue the use of a cardiac device in relationship to your overall health. As you continue to live with these devices, the *benefits* and *burdens* of the devices are best determined by you as patient.

(Initial the appropriate box(es)) **only if applicable**. Additional guidance may be added at No. 7.

I want my Implantable cardioverter-defibrillator (ICD) turned off or deactivated if:

- I am a Do-Not-Resuscitate; or
- I have an incurable illness or injury and am dying; or
- I am admitted to Hospice (e.g., inpatient or home).

I want my Pacemaker turned off or deactivated if:

- I am a Do-Not-Resuscitate; or
- I have an incurable illness or injury and am dying; or
- I am admitted to Hospice (e.g., inpatient or home)

**unless my physician believes deactivation would cause further burden or suffering.**

Not Applicable.



7. My additional guidance to the choices in Sections 1 through 6 is written below. The comments below should be used to interpret and clarify my choices in sections 1 through 6.

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## **Part III – Making the Document Legal Under Wisconsin Law**

### ***Instructions for Completing this Part:***

This document must be signed and dated in the presence of two witnesses who meet the qualifications explained on page 11.

**I am of sound mind, I agree with everything that is written in this document, and I have made this document voluntarily. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, I want my health care agent to be recognized as my chosen surrogate decision-maker and the instructions within this document to be followed based on my legal right to direct my own health care.**

The Principal and both witnesses must all sign the document at the same time.

\_\_\_\_\_  
My signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

**If I cannot sign my name, I can ask an adult to sign this document for me, and in my presence.**

\_\_\_\_\_  
Signature of the adult who I asked to sign this document for me, and in my presence.

\_\_\_\_\_  
Print the name of the adult who I asked to sign this document for me, and in my presence.

#### **Witness Number 1:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Address

#### **Witness Number 2:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Address

## Statement of Witnesses

The principal personally came before me to execute this document and is known to me to be such person or presented to me that s/he is such person. 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 appointed by the person signing this document.
- not related to the person making this document by blood, marriage, domestic partnership or adoption.
- not directly financially responsible for that person's health care.
- not a health care provider directly serving the person at this time.
- not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- not aware that I am entitled to or have a claim against the person's estate.

## Statement of Agent and Alternate Agent

(Signatures of agents are recommended, but not required)

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 be incapacitated and incapable of making his or her own healthcare decisions.

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

Signature of Agent \_\_\_\_\_

Print name of Agent \_\_\_\_\_

Signature of First Alternate Agent \_\_\_\_\_

Print name of First Alternate Agent \_\_\_\_\_

Signature of Second Alternate Agent \_\_\_\_\_

Print name of Second Alternate Agent \_\_\_\_\_

**Donation of My Organs or Tissue for Transplantation:** *(Initial one box.)*

I authorize donation of my organs and tissue for transplantation.

I authorize donation of only the following organs and tissue (name the specific organs or tissue) for transplantation:

I do not authorize donation of any organ or tissue for transplantation.

If you are interested in organ or tissue donation please register at: <http://yesiwillwisconsin.com>

**Donation of My Organs or Tissue for Medical Research:** *(Initial one box)*

*If you wish to donate your body for medical research after death, arrangements must be made in advance. Please contact the Medical College of Wisconsin at: <http://www.mcw.edu/AnatomicalGiftRegistry.htm> or University of Wisconsin-Madison at: <http://www.bdp.wisc.edu>*

In accordance with my selection above, I authorize donation of my organs and tissue for transplantation and the remainder of my body, organs and tissue for medical research.

I authorize donation of my entire body, organs and tissue for medical research.

I do not authorize donation of any part of my body, organs or tissue for medical research.

**Autopsy:** *(Initial any boxes that apply.)*

I do not object to 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 do not object to an autopsy if it can help the advancement of medicine or medical education.

I do not want an autopsy performed on me.

## Next Steps:

Now that you have completed this Power of Attorney for Health Care, please also consider the following:

- Give your health care agent a copy of this document;
- Give a copy of this document to your doctor and make sure your wishes are understood;
- If you go to a hospital or nursing home, bring a copy of this document and present it when requested; and
- Let family and close friends know about this document.

## Part IV – Statement of Desires If My Condition is Likely to Result in Death

Religion:

If I am nearing my death, (initial all that apply)

I want my pastor / spiritual leader notified of my medical condition.

I want a representative of my place of worship with me as I prepare for my death.

I am of the \_\_\_\_\_ faith, and am a member of the  
\_\_\_\_\_ congregation or worship group.

Phone number of congregation or worship group (if known): \_\_\_\_\_

*The following are matters that you may wish to address. If you are not comfortable with this information being in your medical record, you can record it elsewhere.*

**If I am nearing my death, I want the following: (List things that would make dying more meaningful for you.)**

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**If I am nearing my death and cannot speak, I want my friends and family to know:**

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Pages 12 through 14 are intended to provide my health care agent with information about my wishes and desires in addition to those expressed in my Power of Attorney for Health Care. These pages are not intended to replace my Power of Attorney for Health Care. If any of the guidance I have written on pages 12 and 14 conflicts directly with my Power of Attorney for Health Care, I want my wishes and desires expressed in my Power of Attorney for Health Care to control the decision to be made.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print name \_\_\_\_\_