

POWER OF ATTORNEY FOR HEALTH CARE

For

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

**I intend by this document to create a power of attorney for health care.
I execute this power of attorney for health care voluntarily.
I expect to be fully informed about and allowed to participate in
any health care decision for me until the point that I am unable.**

**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.**

Copies of this document have been given to:

1. _____
2. _____
3. _____
4. _____
5. _____

**If you create a new document all previous copies should be replaced with copies
of the new 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 PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVEN GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED 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 DOCUMENT OF GIFT 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 YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

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Part I – Appointing a Health Care Agent

If I am no longer able to make my own health care decisions for myself, due to my incapacity, 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 if I am determined to**

be incapable to make health care decisions as provided under state law. For the purpose of this document, ‘incapacity’ exists if two 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 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. My health care agent should, however, try to communicate to me, in whatever manner is necessary, any proposed health care.

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 agrees to carry out your wishes to the best of their ability given the particular situation and who is able to make difficult decisions in stressful circumstances.** Often family members are good choices, **but not always.** Make sure that you pick someone who will closely follow what you want and will be a good advocate for you. **Take time to discuss this document and your views with the person you pick to be your health care agent & give him/her a copy of this document.**

Your health care agent must be at least 18 years of age and should **not** be your health care provider, employee of that health care provider, employee of a health care facility in which you are a patient or resident, or a spouse of any of those providers or employees, unless the health care provider, employee or spouse of the provider or employee, is your relative.

The person I choose as my health care agent is:

Name: _____ **Relationship:** _____

Address: _____

Phone numbers: Home _____ **Work** _____ **Cell** _____

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:**

First Alternate:

Name: _____ **Relationship:** _____

Address: _____

Phone numbers: Home _____ **Work** _____ **Cell** _____

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 Alternate (Optional)

Name: _____ Relationship: _____

Address: _____

Phone numbers: Home _____ Work _____ Cell _____

Part II – General Authority of the Health Care Agent

It is very important that you discuss your views, values, and this document with your health care agent.

I want my health care agent to be able to direct my medical care including but not limited to the following:

- Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, my health care agent can keep it going or have it stopped depending upon my stated instructions or my best interests.
- Interpret any instruction I have given in this form or in other conversations with them.
- Review, request and release my medical records, personal files and information from my physician(s) & health care providers as needed for my medical care.
- Sign consents or any documents required on my behalf.
- Move me to another state if needed for health care.
- Determine which health professionals and organizations provide my medical treatment.
- In addition to the other powers granted by this document, I grant to my agent the power and authority as Personal Representative for all purposes of the Health Insurance Portability and Accountability Act (HIPPA), 42 USC 1320 (d), and its regulations, including but not limited to authority to review, copy and discuss health information and medical records.

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 mentally retarded or 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.

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Instructions for Completing Part II:

Put your initials in the box (e.g.) in front of your choice in the following three sections. If you do not mark any box in a section and make no clear choice, the statute in Wisconsin states your choice is considered to be “No”. This means that in Wisconsin **if you do not indicate a choice, and become incapable of making a choice, only a court of law or a court-appointed guardian**

may make such a decision for you.

1. Agent authority to admit me to a nursing home, community-based residential facility (CBRF) or group home:

My health care agent may admit me to a nursing home, CBRF or group home for short term stays for recuperative care or respite care. However, if I have checked 'Yes' to the following, my health care agent may admit me for a purpose other than recuperative or respite care.

If I check 'No' to the following, my health care agent may not admit me to a Wisconsin long-term care facility for long-term care without a court order.

Yes No Nursing Home

Yes No CBRF/Group Home

2. Agent authority to order the withholding or withdrawal of feeding tube and I.V. hydration:

My health care agent has authority to have a feeding tube or I.V. hydration withheld or withdrawn from me, subject to any limits I have set forth in this document, unless my physician has advised that in his or her professional judgment this will cause me pain or will reduce my comfort. **If I check 'No', feeding tubes or I.V. hydration cannot be withheld or withdrawn from me in the state of Wisconsin without a court order.**

Yes No

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

My health care agent has authority to make decisions for me if I am pregnant, subject to any limits I have set forth in this document. **If I check 'No', health care decisions cannot be made for me without a court order during my pregnancy.**

Yes No Not Applicable

Part III – OPTIONAL- Health Care Guidance Statements:

These are my desires. They are meant to guide my health care agent in the effort to make decisions on my behalf. If I choose **not** to provide any instructions, my health care agent will make decisions based on my stated instructions or what my agent considers to be in my best interest. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, or my health care agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own health care.

Instructions for Completing Part III:

Place your initials in the box (e.g.) if you agree with the statement and discuss this with your health care agent and health care provider/s.

1. Stopping Attempts of Life Prolonging Treatments:

- If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with my family, friends and environment I want to stop or withhold **all** treatments that might be used to prolong my existence. Treatments I would not want if I were to reach this point include tube feedings or artificial nutrition, I.V. hydration, respirator/ventilator, CPR, antibiotics and dialysis.

2. Pain and Symptom Control

- If I reach a point where efforts to prolong my life are stopped, I want medical treatments, medications and nursing care that will make me comfortable and reduce pain even if it affects my level of comprehension.

3. Cardiopulmonary Resuscitation (CPR):

My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information.

If I do not want CPR, my physician should be made aware of this choice. If I indicate below that I do not want CPR, this choice in itself, will not stop emergency personnel from attempting CPR in an emergency. **Instruction:** If you do not wish emergency personnel to attempt CPR, you should contact your physician to determine your qualification for a State approved DNR (Do Not Resuscitate) bracelet.

- I do not want CPR attempted if my heart stops.
- I want 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 CPR would cause significant suffering.
- I want CPR attempted in any event.

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4. Donation of My Organs or Tissue:

- I wish to donate **only** the following organs or parts if possible (name the specific organs or tissue): _____.
- I wish to donate **any** organs or tissue.
- I do not want to donate any organ or tissue.

Instruction: If you wish to donate your body to medical science, you need to make arrangements ahead of time with a medical school, such as the University of Wisconsin-Madison Medical School or Mayo Medical School.

5. Religion:

I am of the _____ faith and am a member of the _____ congregation, synagogue or worship group.

6. Other Instructions or Limitations I Want My Health Care Agent to Follow:

The contents of this document and any other wishes that you may have regarding end of life care should be discussed with your health care agent, your physician and your family members. Copies of this document should be given to them as well.

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Part IV – Making the Document Legal

Instructions for Completing Part IV:

This document must be signed and dated in the presence of two witnesses with both witnesses signing at that time as well. If I cannot sign my name I can ask someone 18 years of age or older to sign my name for me in front of two witnesses and myself (e.g. John Doe by Jane Smith).

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

My signature

Date

