

*Advanced Directive And Durable Power Of Attorney*  
**Declaration to Physicians (Living Will)**  
**and Power of Attorney for Health Care**

State of Wisconsin

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advanced Directive or Durable Power of Attorney.

**Recap. What Is?**  
**Advanced Directive**

An Advanced Directive is a legal document that specifically spells out how you want to be cared for as the end draws near.

This is a legal document and needs to be in accord with your local State laws.

This must be completed and notarized and/or signed by witnesses. Until electronic signatures are more common, the signed form must be in a defined location which is known to the Health care proxy, the attorney, the doctor.

**Recap. What Is?**  
**Durable Power of Attorney**

An Advanced Directive is not enough. It must be known to your caregivers.

You will need someone to see that your Advanced Directive is adhered to if you are not in a position to do so.

This person is designated by a document called a durable power of attorney for health matters.

You must choose your proxy/surrogate wisely.

The document designating the proxy/surrogate must be notarized and signed

Until electronic signatures are more common, the signed form must be in a defined location which is known to the Health care proxy, the attorney, the doctor.

**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.

**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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.

**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.

**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 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 employe of the health care provider, other than a chaplain or a social worker, or an employe, 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 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.

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