

WISCONSIN Advance Directive Planning for Important Healthcare Decisions

Caring Connections

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Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care

Implement plans to ensure wishes are honored

Voice decisions to family, friends and healthcare providers

Engage in personal or community efforts to improve end-of-life care

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR WISCONSIN ADVANCE DIRECTIVE

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Wisconsin Power of Attorney for Healthcare** lets you name someone to make decisions about your medical care—including decisions about life support—if two physicians (or one physician and one psychologist) determine that you are unable to manage your own healthcare decisions. The Power of Attorney for Healthcare is especially useful because it appoints someone to speak for you any time you are unable to manage your own healthcare decisions, not only at the end of life.

2. The **Wisconsin Declaration to Physicians** is your state's living will. It lets you state your wishes about the withholding or withdrawal of life-sustaining procedures or of feeding tubes in the event that you enter into a persistent vegetative state or develop a terminal condition. Although the Declaration to Physicians will be effective in most circumstances, it may not authorize the withholding or withdrawal of life-sustaining procedures or of feeding tubes if your attending physician determines that such withholding or withdrawal will cause you pain or discomfort.

Note: These documents will be legally binding only if the person completing them is a competent adult who is at least eighteen years old.

COMPLETING YOUR WISCONSIN POWER OF ATTORNEY FOR HEALTHCARE

Whom should I appoint as my Healthcare Agent?

Your healthcare agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your healthcare agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your healthcare agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

Unless he or she is related to you, the person you appoint as your healthcare agent **cannot** be:

- your treating healthcare provider;
- an employee of your treating healthcare provider;
- an employee of a healthcare facility in which you reside or are a patient; or
- a spouse of any of the above.

You can appoint another person as your alternate healthcare agent. The alternate will step in if the first person you name as your healthcare agent is unable or, unwilling to act for you.

How do I make my Wisconsin Power of Attorney for Healthcare legal?

The law requires that you date and sign your Power of Attorney for Healthcare in the presence of two adult witnesses. If you are physically unable to sign, another adult can sign for you at your express direction and in your presence. The two witnesses must sign a statement acknowledging that you are of sound mind and that you signed the Power of Attorney for Healthcare voluntarily. These witnesses **cannot be**:

- related to you by blood, marriage or adoption;
- entitled to, or have a claim against, any portion of your estate;
- directly financially responsible for your healthcare;
- your healthcare provider;
- an employee of your healthcare provider, other than a chaplain or a social worker;
- an employee of an inpatient healthcare facility in which you are a patient, other than a chaplain or a social worker; or
- your healthcare agent.

Note: You do not need to notarize your Wisconsin Power of Attorney for Healthcare.

COMPLETING YOUR WISCONSIN POWER OF ATTORNEY FOR HEALTHCARE (CONTINUED)

Should I add personal instructions to my Wisconsin Power of Attorney for Healthcare?

One of the strongest reasons for naming a healthcare agent is to have someone who can respond flexibly as your medical condition changes. If you add instructions, you might unintentionally restrict your healthcare agent's power to act in your best interest.

Talk with your healthcare agent about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes regarding the withholding or withdrawal of life-sustaining procedures or of feeding tubes, you should use your Wisconsin Declaration to Physicians (the living will).

What if I change my mind?

You may revoke your Wisconsin Power of Attorney for Healthcare at any time, by:

- defacing, burning, tearing, or otherwise destroying the document itself;
- signing and dating a written statement of your intent to revoke your Wisconsin Power of Attorney for Healthcare;
- expressing your intent to revoke your Wisconsin Power of Attorney for Healthcare verbally in the presence of two witnesses; or
- executing another Wisconsin Power of Attorney for Healthcare.

If you use this document to make or refuse an anatomical gift, you may revoke or change any anatomical gift that you make by crossing out the anatomical gifts provision in the Wisconsin Power of Attorney for Healthcare.

COMPLETING YOUR WISCONSIN DECLARATION TO PHYSICIANS

How do I make my Wisconsin Declaration to Physicians legal?

The law requires that you sign your Declaration in the presence of two witnesses. If you are physically unable to sign, another adult can sign at your express direction and in your presence. The two witnesses must sign a statement acknowledging that they personally know you and believe you to be of sound mind. These witnesses **cannot** be:

- related to you by blood, marriage or adoption;
- entitled to or have a claim on any portion of your estate;
- directly financially responsible for your healthcare;
- your attending healthcare provider or an employee of your attending healthcare provider, other than a chaplain or a social worker; or
- an employee of an inpatient healthcare facility in which you are a patient, other than a chaplain or a social worker.

Note: You do not need to notarize your Wisconsin Declaration to Physicians.

Can I add personal instructions to my Declaration to Physicians?

One of the strongest reasons for executing a Declaration to Physicians is to have a clear statement of your intentions regarding the withdrawal or withholding of life-sustaining procedures or feeding tubes. If you add instructions, you might unintentionally restrict the effectiveness of your Declaration.

If you have appointed a healthcare agent, talk about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your Declaration to Physicians at any time by:

- canceling, defacing, obliterating, burning, tearing or otherwise destroying the document;
- signing and dating a written revocation;
- executing a subsequent Declaration to Physicians; or
- orally expressing your intent to revoke the Declaration. An oral revocation only becomes effective if your attending physician is notified of the revocation.

What other important facts should I know?

A pregnant patient's Wisconsin Declaration to Physicians will not be honored due to restrictions in the state law.

WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE
PAGE 1 OF 8

NOTICE TO PERSON MAKING THIS DOCUMENT

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE 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 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.

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME,
ADDRESS AND
DATE OF BIRTH

PRINT THE NAME,
ADDRESS, AND
PHONE NUMBER
OF YOUR AGENT

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WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE
PAGE 2 OF 8

**WISCONSIN POWER OF ATTORNEY
FOR HEALTH CARE**

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

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, _____
(print name)

(address)

(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.

**WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE
PAGE 3 OF 8**

PRINT THE NAME,
ADDRESS AND
PHONE NUMBER
OF YOUR
ALTERNATE AGENT

If he or she is ever unable or unwilling to do so, I hereby designate

(print name)

(address)

(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.

**WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE
PAGE 4 OF 8**

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, 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 other 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 only admit me for short-term stays for recuperative care or respite care.

PROVISION OF A 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.

IF YOU WANT TO GIVE YOUR AGENT THE POWER TO ADMIT YOU TO A NURSING HOME, CHECK "YES"

IF YOU WANT TO GIVE YOUR AGENT THE POWER TO REFUSE TUBE FEEDING ON YOUR BEHALF, CHECK "YES"

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**WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE
PAGE 5 OF 8**

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

IF YOU WANT YOUR AGENT TO MAKE MEDICAL DECISIONS FOR YOU IF YOU BECOME INCAPACITATED DURING PREGNANCY, CHECK "YES"

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**

ADD PERSONAL INSTRUCTIONS (IF ANY)

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 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.

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**WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE
PAGE 6 OF 8**

(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 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 No. 1:

(print) Name _____ Date _____

Address _____

Signature _____

Witness No. 2:

(print) Name _____ Date _____

Address _____

Signature _____

SIGN AND DATE
YOUR DOCUMENT

WITNESSING
PROCEDURE

TWO WITNESSES
MUST READ THIS
STATEMENT
BEFORE SIGNING
YOUR DOCUMENT

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**WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE
PAGE 7 OF 8**

STATEMENT OF HEALTH CARE AGENT
AND ALTERNATE HEALTH CARE AGENT

PRINT YOUR NAME

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.

PRINT YOUR NAME

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

YOUR AGENT AND
ALTERNATE AGENT
MUST
SIGN THEIR NAMES
AND PRINT THEIR
ADDRESSES

Agent's signature _____

Address _____

Alternate agent'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 is executed as provided in chapter 155 of the Wisconsin Statutes.

**WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE
PAGE 8 OF 8**

ANATOMICAL GIFTS
(OPTIONAL)

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 of principal)

(date)

CHECK THE
STATEMENT
THAT REFLECTS
YOUR WISHES

SIGN YOUR
NAME & PRINT
THE DATE

**WISCONSIN DECLARATION TO PHYSICIANS
(LIVING WILL) - PAGE 1 OF 3**

INSTRUCTIONS

PRINT YOUR NAME

I, _____,

(print name)

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.

CHECK THE STATEMENT THAT BEST REFLECTS YOUR WISHES REGARDING FEEDING TUBES IN THE EVENT YOU HAVE A TERMINAL CONDITION

1. If I have a **TERMINAL CONDITION**, as determined by two 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.)

CHECK THE STATEMENT THAT BEST REFLECTS YOUR WISHES REGARDING LIFESUSTAINING PROCEDURES IN THE EVENT YOU ARE IN A PERSISTENT VEGETATIVE STATE

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by two 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.)

**WISCONSIN DECLARATION TO PHYSICIANS
(LIVING WILL) - PAGE 2 OF 3**

CHECK THE STATEMENT THAT BEST REFLECTS YOUR WISHES REGARDING TUBE FEEDING IN THE EVENT YOU ARE IN A PERSISTENT VEGETATIVE STATE

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by two 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 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 TWO 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.

WITNESSING PROCEDURE

SIGN AND DATE THE DOCUMENT PRINT YOUR ADDRESS AND DATE OF BIRTH

TWO WITNESSES MUST SIGN ON THE NEXT PAGE

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**WISCONSIN DECLARATION TO PHYSICIANS
(LIVING WILL) - PAGE 3 OF 3**

TWO WITNESSES
SIGN AND DATE
THE DOCUMENT
AND PRINT
THEIR NAMES

Witness signature _____ Date signed _____

Print Name _____

Witness signature _____ Date signed _____

Print Name _____

DIRECTIVES TO ATTENDING PHYSICIANS

1. This document authorizes the withholding or withdrawing of life-sustaining procedures or of feeding tubes when two 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 the withholding or withdrawing of 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 do so constitutes unprofessional conduct.
4. If you know that the patient is pregnant, this document shall have no effect during her pregnancy.

DIRECTIVES TO
PHYSICIANS

LOCATION OF COPIES

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:

PRINT THE NAMES
OF PEOPLE TO
WHOM YOU WILL
GIVE COPIES OF
THIS DOCUMENT

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Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Advance Directive, Now What?

1. Your Wisconsin Declaration to Physicians and Wisconsin Power of Attorney for Healthcare are important legal documents. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed originals to your healthcare agent and alternate healthcare agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records. You may also file the documents with the register in probate of the county in which you reside.
3. Be sure to talk to your healthcare agent and alternate, your doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke one or both of your Wisconsin documents. If you revoke your documents, make sure you notify your agent, alternate agents, your family and your doctors.
6. Be aware that your Wisconsin documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**