INTRODUCTION TO YOUR WISCONSIN ADVANCE DIRECTIVE

This packet contains a legal document, a **Wisconsin Advance Directive**, that protects 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. You may complete Part II, Part III, or both, depending on your advance-planning needs. You must complete Part IV.

Part I contains a statutory notice that explains the significance of Part II, the Wisconsin Power of Attorney for Health Care.

Part II, The **Wisconsin Power of Attorney for Health Care**, lets you name someone, your "health care agent," to make decisions about your medical care—including decisions about life-sustaining procedures—if you can no longer make your own health care decisions. The Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to manage your own health care decisions, not only at the end of life.

Your Power of Attorney for Health Care goes into effect when your doctor and one other doctor determines that you are unable to receive and evaluate information effectively or to communicate decisions to such an extent that you lack the ability to manage your health care decisions.

Part III, 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.

Your Declaration will go into effect when your doctor and one other doctor certify in writing that you are no longer able to make or communicate your health care decisions, and you have a terminal condition or are in a persistent vegetative state.

Part IV contains the signature and witnessing provisions so that your document will be effective.

Following your advance directive is a **Wisconsin Organ Donation Form**

This form only minimally addresses health care decisions for mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

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 ADVANCE DIRECTIVE

How do I make my Wisconsin Advance Directive legal?

The law requires that you date and sign your Advance Directive or have an adult date and sign at your direction and in your presence. You must sign in the presence of two adult witnesses. These witnesses **cannot be:**

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

Whom should I appoint as my health care agent?

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

You can appoint a second person as your alternate health care agent. The alternate will step in if the first person you name as a health care agent is unable, unwilling, or unavailable to act for you.

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

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

Should I add personal instructions to my Wisconsin Advance Directive?

One of the strongest reasons for naming a health care agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your health care agent carry out your wishes, but be careful that you do not unintentionally restrict your health care agent's power to act in your best interest. In any event, be sure to talk

with your health care agent 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 Wisconsin Advance Directive 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 Health care;
- expressing your intent to revoke your Wisconsin Advance Directive verbally in the presence of two witnesses (this revocation becomes effective only your doctor is notified of the revocation); or
- executing another Wisconsin Advance Directive.

If you appoint your spouse or registered domestic partner, and you obtain a divorce, the marriage is annulled, or the domestic partnership is terminated, the power of attorney for health care is automatically revoked.

Is there anything else I should know?

If you are pregnant, you must initial the paragraph on page 6 of the form for Part II (Power of Attorney for Health Care) to be effective during your pregnancy. Part III (Declaration to Physicians) is not effective during your pregnancy.

Your health care agent does not have the authority to consent to:

- admitting or committing you on an inpatient basis to an institution for mental diseases,
- admitting or committing you to an intermediate care facility for the mentally retarded, a state treatment facility or a treatment facility,
- experimental mental health research or psychosurgery, or
- electroconvulsive treatment or other "drastic" mental health treatment procedures.

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

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have initialed "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 initialed "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 initialed 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 specific desires, provisions or limitations that I wish to state (add more items if needed):

_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

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.

PART III

PRINT YOUR NAME

PART III. DECLARATION TO PHYSICIANS

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.

Automatic revocation under Wis. Stat. § 155.40(2) of the Power of Attorney for Health Care in Part II due to the principal's divorce, annulment of marriage, or termination of domestic partnership with his or her health care agent shall have no effect on this Declaration, Part III, which shall survive the invalidation of Part II.

INITIAL 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 initialed either box, feeding tubes will be used**.)

INITIAL 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 initialed either box, life-sustaining procedures will be used**.)

INITIAL 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 initialed 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.

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.

LOCATION OF COPIES

ADD PEOPLE WHO YOU PLAN TO GIVE COPIES OF YOUR DOCUMENT

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:

_____ _____

_____ _____

PART IV

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR NAME

THE PRINCIPAL AND THE WITNESSES ALL MUST SIGN THE DOCUMENT AT THE SAME TIME

WITNESSES MUST SIGN AND PRINT THEIR NAMES, DATE, AND ADDRESSES HERE

PART IV. EXECUTION

Signature _____ Date _____

Printed Name _____

(The signing of this document by the principal revokes all previous powers of attorney for health care and declaration to physicians 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:

Signature _____

(print) Name _____ Date _____

Address _____

Witness No. 2:

Signature _____

(print) Name _____ Date_____

Address _____

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

ANATOMICAL GIFTS (OPTIONAL)

ANATOMICAL GIFTS (OPTIONAL)

Upon my death:
_____ I wish to donate only the following organs or parts:

_____
(specify the organs or parts)

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

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

SIGN AND PRINT YOUR NAME AND THE DATE

_____ _____
(signature of principal) (date)

_____
(printed name of principal)

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

You Have Filled Out Your Health Care Directive, Now What?

1. Your Wisconsin Advance Directive is an important legal document. 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 original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), 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. Wisconsin does not maintain an Advance Directive Registry. However, you may record your advance directive with the registry of probate in the county of your residence.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your Wisconsin document.

8. Be aware that your Wisconsin document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives, called "do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Wisconsin law authorizes such orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

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YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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OR donate online today: www.NationalHospiceFoundation.org/donate