MAKING ADVANCE CARE DECISIONS
PHILLIPS HIGH SCHOOL

For a health young adult, this is a fairly simple process, but we still strongly suggest going through your document with a trained advance care planning facilitator to make sure it reflects your wishes and is also done correctly and legally, though this document does not require the services of an attorney. The Power of Attorney for Health Care can be activated any time you are incapable of making complex medical decisions, even if it is only temporarily. As soon as you regain your ability to make medical decisions, you once again resume being the decision-maker.

What you need to do:

- Appoint a health care agent and alternate(s); this is an extremely important part of the document and needs to be carefully considered as these are the people who will be your advocates if you can no longer make medical decisions. Talk to the people that you are considering for these roles (see *"Responsibilities of a Health Care Agent Under Wisconsin Law"* and *"Choosing Your Health Care Agent"*) and make sure they are willing to do this for you. It is also important to get their current address and all phone numbers (home, work, cell, pager).
- Make sure that you know your current health care needs if any exist
- Discuss any possible religious, moral or cultural views that you have that could influence medical decision-making
- Contact Flambeau Home Health and Hospice at **715-339-4371** for assistance in completing your document

And have a great senior year!

CHOOSING YOUR HEALTH CARE AGENT

- It may be anyone **except** a health care provider or employee of a health care provider or spouse of any of these health care providers **unless** the person is a relative.
- It does not need to be the same person that you have designated (if you have) to handle your financial affairs.
- It should be someone who is emotionally close to you, and yet still will be able to make potentially difficult decisions.
- It should be someone who can be a good advocate for you, who will not just give in to decisions that health care providers make, but ask questions, get information and insist on your wishes being followed regarding your care. It should be someone who also is aware of your goals and values regarding your care, lifestyle, etc. and who can use those as additional guidelines in determining your health care.
- It should be someone who can be trusted enough to carry out **your** wishes, even if they are different from the person's own preferences.
- It should be someone who is either geographically close, or can easily be reached no matter where they are.
- It should be someone who is capable of understanding sometimes complex medical information.

RESPONSIBILITIES OF A HEALTH CARE AGENT UNDER A WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE

INTRODUCTION

You have been chosen by a loved one or friend (the **principal**), to serve as **agent** under a power of attorney for health care document. You have undertaken an important responsibility by agreeing to act as agent if the principal is ever unable to advocate for him or herself due to disability. The principal has chosen you as agent because he or she trusts you to implement his or her health care wishes *even if you disagree with those decisions.*

A health care agent makes "health care" decisions on behalf of a principal whenever the principal is not able to make those decisions him or herself because of incapacity. Many health care providers and individuals believe that family members, such as spouses, can legally make health care decisions on behalf of their loved ones. T*his is not the law, however.* In Wisconsin, only a person's legally authorized representative – an agent under a valid power of attorney for health care document or a court-appointed guardian of the person – may provide informed consent to health care treatment on behalf of another adult. The duties of a health care agent are described in Chapter 155 of the Wisconsin Statutes. The following information explains these duties and may assist you in determining how to best fulfill your role.

WHEN DOES AN AGENT'S AUTHORITY TO MAKE DECISIONS BEGIN?

Most power of attorney for health care documents provide that the document becomes "activated" when two physicians or one physician and one psychologist personally examine the principal then sign a statement asserting (certifying) that the principal is incapacitated. Incapacity means the principal is not able to "receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions." This certification of incapacity must be attached to the document.

Some individually-tailored power of attorney for health care documents provide for an alternate method of activation. For example, an agent may have authority to make medical decisions on behalf of the principal when the principal has been determined incapacitated by only one physician. Check your principal's document to determine when your authority to make decisions begins.

WHAT TYPES OF DECISIONS MAY AN AGENT MAKE?

As agent, you may only make "health care" decisions. "Health care" is defined as "any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental condition." Thus, depending on the exact language of the document, you may choose medical professionals and facilities, and consent to surgical procedures and medications. You may also make certain end-of-life decisions on the principal's behalf **if** the principal has delegated that authority to you. *Please note*: you do not have authority to decide non-medical issues, such as who may visit the principal at a nursing home, or whether the principal may smoke.

Keep in mind that your decision-making authority is not only about end of life decisions. If you are an agent for an individual with a chronic illness or long-term mental disability, you may be the agent for many years.

WHAT STANDARD DOES AN AGENT USE TO MAKE HEALTH CARE DECISIONS?

As agent, you must act in good faith consistently with the desires of the principal as expressed in the power of attorney for health care document or as otherwise specifically directed by the principal to you **at any time** – even after certification of incapacity. You may not make medical decisions based on your own religious or moral views regarding the particular treatment. The law provides specific guidance on how you make medical decisions on behalf of a principal, as follows:

- First, you determine what the principal's current wishes are regarding his or her treatment, if the principal is capable of expressing those wishes. You are obligated to follow the treatment wishes of the principal as expressed at any time, *even after the principal has been determined incapacitated.* This is true even if the principal can only express his or her wishes by nodding his or her head or blinking his or her eyes.
- Second, if the principal is currently unable to express his or her wishes, you may rely on the principal's previously expressed treatment wishes. These wishes may be contained in the power of attorney document itself, or may have been expressed verbally to you or other family and friends.
- Finally, if the principal has never expressed his or her wishes regarding the treatment, and is currently unable to express those wishes, you may make the medical decision based on what you feel would be in the principal's best interests. You should consider the principal's values and beliefs when making this decision.

If you have not done so already, you should immediately speak with the principal about his or her wishes regarding medical treatment. Determine preferences the principal has in regards to treatment professionals and medication. Discuss end-of-life treatment at length. If the individual has a Living Will, obtain a copy of the Living Will and discuss the decisions the principal made in that document. Learn the person's values and beliefs about various medical treatment options. If the principal is not able to discuss his or her treatment preferences, ask family and friends if the principal had discussed health care treatment with them at any time.

Are There Medical Decisions an Agent Is Prohibited In Making under Any Circumstances?

Under Wisconsin law, you cannot consent to admission of the principal to an institution for mental diseases, an intermediate care facility for the mentally retarded, to a state treatment facility or a treatment facility. Additionally, you may not consent to experimental mental health research or to psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for the principal.

May an Agent make every Health Care Decision?

Not automatically. As agent there are certain health care decisions you may not make unless the principal has given you specific authority in the document itself. These include:

- Admitting the principal to a community based residential facility or nursing home for long term placement.
- Consenting to the withholding or withdrawal of feeding tubes.
- Making health care decisions if you know the principal is pregnant.

If the principal has not given you specific authority to admit him or her to a nursing home or community based residential facility for long term placement, you will need to go to court to be appointed guardian and obtain a protective placement order to have this authority.

What Authority Does an Agent Have To Admit A Principal to A Residential Facility?

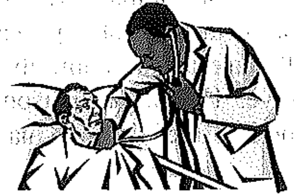
As agent, you may admit a principal to a nursing home or community based residential facility for **long term care** only if the principal has given you that specific authority in the power of attorney for health care document, **and** if the principal is <u>not</u> diagnosed as developmentally disabled or as having mental illness at the time of the proposed admission. As agent, you may admit a principal to a nursing home for a **short term stay** (up to 90 days) for recuperative care if the principal is admitted directly from a hospital inpatient unit, unless the hospital admission was for psychiatric care, regardless of whether or not the principal has specifically authorized you to admit the principal for long term care in the principal's document. Also, if you and the principal live together, you may admit the

principal to a nursing home or community based residential facility temporarily for up to 30 days to go on vacation or to deal with a family emergency.

All of the above statutory ways to admit a principal to a facility may only be used when the principal is **not objecting** to the admission. If the individual objects, and you still believe it is necessary to place the individual in a nursing home or community based residential facility, you must go to court to obtain a guardianship and protective placement order.

How Can an Agent Best Advocate for the Principal in Making Medical Decisions?

To assure that the principal is receiving adequate care, an agent should:



- Prior to admitting an individual to a nursing home or other facility, explore all possible options to determine the best residential setting for the principal that least imposes restrictions on the individual's liberty, and provides as many activities and amenities as possible. Check out staff ratios and qualifications and the facility's general reputation for quality care.
- Visit the principal as often as possible, but at least once a month, and more often if the principal is experiencing rapidly changing medical conditions. **You may be the only sentinel to protect the individual from abuse or neglect whether the individual lives at home or in a facility.**
- Attend facility staffings related to medical care for the principal.
- Become knowledgeable about the principal's medical conditions through resources such as medical dictionaries, medical journals and the Internet. Be advised of and research possible treatment options, risks and benefits of various treatments, and side effects of medication. Review the principal's medical records, and get second medical opinions where appropriate. Release medical records to appropriate professionals.
- Provide informed consent or refusal for all of the principal's health care needs. Insist that providers contact you with details about any change in the principal's medical condition, adverse medication reactions, and injuries.
- Become familiar with the resident's rights in the facility where the principal resides. You should be given a copy of these rights when admitting a principal to a facility.
- If the principal has no guardian of the estate or agent under a power of attorney for finances document, you may apply for government benefits, such as Medical Assistance, on the individual's behalf, and become the individual's representative payee.

When Do My Duties as Agent Come To an End?

Your duties as agent may come to an end in any one of the following ways:

- If the **principal dies**, your authority ceases by law.
- If the **principal revokes** his or her power of attorney for health care document, your authority ceases when you (or your principal's health care providers) receive notice of the revocation. A principal may revoke a Wisconsin power of attorney for health care document **at any time**, even after incapacity, by doing any of the following: 1) canceling, defacing, obliterating, burning, tearing or otherwise destroying the document, or directing another in his or her presence to so destroy it; 2) executing a signed and dated written statement, expressing his or her intent to revoke the document; 3) verbally expressing his or her intent to revoke the document in the presence of two witnesses; or, 4) executing a subsequent power of attorney for health care document. Additionally, the principal's document is automatically revoked and invalid if you and the principal are married and your marriage is later annulled or you divorce. You are obligated by law to notify all of the principal's health care providers if the principal's document is revoked. The provider must record this revocation in its files.

- You may become **unwilling or unable to serve as agent** because of death, disability or other reason. If so, the person designated as alternate agent will begin to serve as agent. If there is no alternate agent, the principal will need to have a court-appointed legal guardian.
- In some cases, as agent under a power of attorney for health care document you **may be removed in judicial proceedings**, such as where a legal guardian has been appointed (see below), or as a result of an interested person petitioning the court to review your performance as agent.

WHAT IS THE ROLE OF THE ALTERNATE AGENT?

The principal may have chosen an alternate agent to serve when the primary agent is unable to serve. Decision making for an incapacitated principal is not joint between an agent and alternate agent, but successive. This means that the alternate agent's authority only begins when the primary agent has died or becomes otherwise unable or unwilling to serve. Having one person at a time serve as agent helps promote continuity of care for the principal through consistent and informed decision making, and avoids family conflict possibly resulting in guardianship.

WHAT IS THE RELATIONSHIP BETWEEN GUARDIANSHIP AND A POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT?

One of the most important reasons individuals execute power of attorney for health care documents is to avoid the need for invasive, costly and time-consuming court procedures to appoint a guardian if they become incompetent. Family, friends or other interested persons, however, may seek guardianship of the person and/or estate despite the principal having executed a power of attorney for health care document. For example, a family member of the principal may feel, rightly or wrongly, that the agent is not fulfilling his or her duties as agent and file a petition to become the individual's guardian. Or, a decision may be needed in an area that the power of attorney does not address.

Where a petition for guardianship has been filed, the court must consider appointing the agent named by the principal as guardian of the person, although it need not if it is not in the best interests of the incompetent person. If the court appoints a guardian of the person, the power of attorney for health care document is revoked and invalid, unless the court finds that the power of attorney for health care should remain in effect. If the court makes this finding, the guardian for the individual may not make health care decisions for the ward that may be made by the health care agent, unless the guardian is also the health care agent.

AS HEALTH CARE AGENT, WHEN ARE YOU LIABLE?

You are not personally liable for medical costs incurred by the principal, including the cost of the nursing home or other facility, unless you are the spouse of the principal.

No health care agent may be charged with a crime or held civilly liable for making a decision in good faith under a power of attorney for health care document.

Reproduction of this brochure is encouraged, provided credit to the Elder Law Center of the Coalition of Wisconsin Aging Groups is retained.

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Coalition of Wisconsin Aging Groups
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Madison, WI 53718-6751
(608) 224-0660 ☎ / (608) 224-0607 Fax
1-800-488-2596

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7/00

How to Complete This
Power of Attorney for Health Care

Overview

The attached form is a legal document that enables a person to create a Power of Attorney for Health Care that will meet the basic requirements of Wisconsin law.

This form allows you to appoint another person and alternate persons to make your 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 agent authority to make your decisions only when you have been determined incapable by your physician(s) to make your health care decisions. It does not give your healthcare agent authority to make certain decisions about your mental health treatment. In addition, it does not give your health care agent any authority to make your financial or other business decisions.

Before completing this Power of Attorney for Health Care form, read it carefully. **It is also very 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 and you do not make a clear plan together, your views and values might not be fully respected if they are not known or understood.

If you want to document your views about future health care, but do not want to or cannot use this Power of Attorney for Health Care form, ask your health care organization or attorney about alternatives.

Steps to Complete This Document

1. Carefully read and follow instructions for each section.
2. Complete the information on page 1 "Power of Attorney for Health Care."
3. 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.
4. Part II — **General Authority of the Health Care Agent**
   Complete by indicating your choices in Sections 1, 2, and 3.
5. Part III — **Statement of Desires, Special Provisions or Limitations**
   Complete by indicating your desires, provisions or limitations for care.
6. Part IV — **Making the Document Legal**
   Complete by signing and dating the document in front of two witnesses. Have the witnesses sign and date the document at the same time. If you are using an addendum, have this signed and dated at this time also by yourself and the same witnesses.

After Completing This Document

After you sign and date the Power of Attorney for Healthcare document, make copies to be given out as follows:

- Two copies for yourself; one to keep at home and one to bring with you when traveling
- Copies for each health care agent & alternates listed in the document
- One copy to give to your physician; review this with him/her at your next appointment
- One copy for your record at the hospital where you would likely go in an emergency
- Extra copies to give to others if you wish (loved ones, your clergy, your attorney, etc.); discuss your wishes with them at this time
- One copy to each healthcare provider you may have (e.g. home health, hospice, etc.)

NOTE: Make sure everyone who has a copy is listed on pg. 1 of the Power of Attorney for Healthcare Form under "Copies of this document have been given to". A photo or fax copy is as legally valid as an original.

Donating Your Body to Science

If you wish to donate your body to medical science after death, you should contact the closest medical school in the state and make arrangements through that school. Please note that they do not accept all bodies and there may be a cost involved. Here are some places to contact:

Medical College of Wisconsin, Milwaukee	414-456-8261 or 1-800-272-3666 (switchboard)
University of Wisconsin School of Medicine and Public Health Sciences	608-263-4900

Need assistance?

If you need assistance to complete this document, contact:

- Flambeau Home Health and Hospice 715-339-4371
- Park Manor Social Services Dept. 715-762-2449
- Community Bioethics Committee of Price County 715-339-1994

Power of Attorney for Health Care
For

Name _______________________________ Date of Birth ______________

Address _______________________________

City ______________ State ______________ Zip ______________

Telephone ______________ Date Document Completed ______________

Copies of this document have been given to:

	Name:	Sent/delivered on:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Notice to the 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.

To avoid this problem, you may sign this legal document to specify a person who you would want to make health care decisions for you if you become 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(s) you specify. 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 regarding particular health care decisions, he or she is required to determine what would be in your best interests in making decisions.

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 *and a new document should be completed immediately.*

You may also use this document to make or refuse to make any 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 intended 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 an original of this document on file with your physician.

Part I - Appointing a Health Care Agent

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 state law. To be determined incapable, two physicians or a physician and a psychologist who have personally examined me would need to declare me 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.

Instructions for completing Part I:
When selecting someone to be your Health Care Agent, pick someone who knows you well, whom you trust, who is willing to respect your views and values, 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. Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your agent(s). If possible, it is advisable to have at least one alternate in addition to your agent.

Your Health Care Agent and alternate Health Care Agent(s) must be at least 18 years old and must not be your health care provider or an employee of your health care provider or health care facility, or a spouse of any of those providers or employees unless the individual is a close relative of yours. Space has been provided for a second and third choice. There is provision for a fourth choice (3rd alternate) on the addendum if you choose to use it. Please check below if you do so.

The person I choose as my Health Care Agent is:
Name:________________________________ Cell phone:________________________
Day phone:____________________________ Evening phone:____________________
Address: ____
City:____________________________ State:____________________ Zip:__________

If this Health Care Agent is unable or unwilling to make these choices for me, or if my spouse is designated as my Health Care Agent and our marriage is annulled or we are divorced or legally separated, then my next choice for a Health Care Agent is:

Second Choice (optional)
Name:________________________________ Cell phone:________________________
Day phone:____________________________ Evening phone:____________________
Address: ____
City:____________________________ State:____________________ Zip:__________

If this Health Care Agent is unable or unwilling to make these choices for me, or if my spouse is designated as my Health Care Agent and our marriage is annulled or we are divorced or legally separated, then my next choice for a Health Care Agent is:

Third Choice (optional)
Name:________________________________ Cell phone:________________________
Day phone:____________________________ Evening phone:____________________
Address: ____
City:____________________________ State:____________________ Zip:__________

___ *See addendum for additional alternate choices*

Part II - General Authority of the Health Care Agent

I want my Health Care Agent to be able to:

- Make choices for me about my medical care or services, such as tests, medicine, and surgery. If treatment has already started, my Health Care Agent can keep it going or have it stopped depending upon my stated instructions or my best interest.
- 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.
- Review and release my medical records and personal files as needed for my medical care.
- Move me to another state if needed.
- Determine which health professionals and organizations should provide my medical treatment.
- Take all other actions or make all other decisions for me that a health care agent is allowed to make under state law.

(If you have any concerns about the above statements, you can state your preferences on pg. 7 under "Other Instructions..." or in the addendum.)

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 mental health treatment facility. My Health Care Agent may not consent to experimental health research or psychosurgery, electro convulsive treatment or drastic mental health treatment procedures for me.

Instructions for Completing Section II:
Put your initial on the line of the statement that you've chosen (e.g. **DJ** *) to indicate you have selected a "yes", "no" or "not applicable" in the next sections. Draw a line through every statement that you do* ***NOT*** *want (e.g. ~~No, my healthcare agent...~~). If you do not initial any line in a section and make no clear choice, the statute in Wisconsin says your choice is considered to be "no." This means that if you do* ***not*** *indicate a choice, in Wisconsin only a court may make such a decision and not your healthcare agent.*

NOTE: *If you are unable to write your initials, you may ask another person to do this for you in your presence.*

1. Agent authority to admit me to a nursing home for the purpose of long-term care.

______ **Yes,** my healthcare agent has authority, if necessary, to admit me to a nursing home for a long-term stay, subject to any limits I have set forth in this document.

______ **No,** my healthcare agent does not have authority to admit me to a nursing home for a long-term stay. *If you initial "no", or leave this section blank, you cannot be admitted to a Wisconsin long-term care facility without a court order.*

2. Agent authority to admit me to a community-based residential facility for long-term care.

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

______ **No,** my healthcare agent does not have authority to admit me to a community-based residential facility for a long-term stay. *If you initial "no", or leave this section blank, you cannot be admitted to a Wisconsin long-term care facility without a court order.*

3. Agent authority to order the withholding or withdrawal of feeding tube.

_____ **Yes,** my healthcare agent has authority to have a feeding tube withheld or withdrawn from me subject to any limits I have set forth in this document.

_____ **No,** my healthcare agent does not have authority to have a feeding tube withheld or withdrawn from me. *If you initial "no", or leave this section blank, feeding tubes cannot be withheld or withdrawn in Wisconsin without a court order unless your physician believes it will cause you pain or will reduce your comfort.*

4. Agent authority to order the withholding or withdrawal of I.V. hydration.

_____ **Yes,** my healthcare agent has authority to have I.V. hydration withheld or withdrawn from me subject to any limits I have set forth in this document.

_____ **No,** my healthcare agent does not have authority to have I.V. hydration withheld or withdrawn from me. *If you initial "no", or leave this section blank, I.V. hydration cannot be withheld or withdrawn in Wisconsin without a court order, unless your physician believes it will cause you pain or will reduce your comfort.*

5. Agent authority to make decisions if I am pregnant.

_____ **Yes,** my healthcare agent has authority to make decisions for me if I am pregnant, subject to any limits I have set forth in this document.

_____ **No,** my healthcare agent does not have authority to make decisions for me if I am pregnant. *If you initial "no", health care decisions cannot be made for you without a court order during pregnancy.*

_____ **Not applicable.**

Part III - Statements of Desires, Special Provisions or Limitations

My healthcare agent shall make health care and related decisions consistent with my stated desires and values, and is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my healthcare agent and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, or my healthcare 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:

*You are **not** required to provide any written instructions or make any selections in Part III. Put your initial on the line of the statement that you've chosen (e.g. DJ) If you are unable to write your initials, you may ask another person to do this for you in your presence. Draw a line through every statement that you do **NOT** want. If you choose not to provide any instructions, your healthcare agent will make decisions based on your oral instructions or what is considered your best interest. If you choose not to provide any instructions, draw a line and write "no instructions" across that section. See the "Addendum" section for further choice options.*

Stopping or Not Attempting Life-Prolonging Treatments:

_____ I value a full life more than a long life. If I have lost the ability to interact with others and have no reasonable chance of regaining this ability; or if my suffering is intense and irreversible, even though I have no terminal illness, I do not want to have my life prolonged. I would not then ask to be subjected to surgery or to resuscitation procedures, to intensive care services, or to life-prolonging measures, including the administration of antibiotics (other than for comfort), blood products or artificial nutrition or hydration.

Pain and Symptom Control:

_____ My goal for pain management is total relief of pain. Err on the side of over-medication rather than under-medication, even if taking such may increase sedation.

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 become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. If I indicate below that I do not want CPR attempted, this choice, in itself, may not stop emergency personnel from attempting CPR in an emergency. Other documents may be needed to control the actions of emergency personnel. ***(Initial only one choice)***

_____I want cardiopulmonary resuscitation (CPR) attempted if my heart stops.

_____I do not want CPR attempted if my heart stops.

_____I want cardiopulmonary resuscitation 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.

Religion:
I am of the ____________________ faith, and am a member of the ____________________ congregation, synagogue, or worship group. Congregation, synagogue, or worship group phone number (if known):____________________

Other instructions or limitations I want my Health Care Agent to follow:
☐ See Addendum

____

____

____

____

If I am nearing my death, I want the following: (List the type of care, ceremonies, etc. that would make dying more meaningful for you.)

____

____

____

If I am nearing my death and cannot speak, I want my friends and family to know I have the following thoughts and feelings:

____

____

Directives Upon My Death:

After my death, the following are my instructions. If my Health Care Agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

Donation of My Organs or Tissues:

______I wish to donate only the following organs or tissues if possible (name the specific organs or tissues):

____

______I wish to donate any organs or tissues if I am a candidate.

______I do not want to donate any organs or tissues.

Body Donation:

If you wish to donate your body to medical science after death, you should contact the closest medical school in your state and make arrangements through that medical school. Please note that they do not accept all bodies and there may be a cost involved. Here are some places to contact in Wisconsin:

- University of Wisconsin School of Medicine and Public Health Sciences 608-262-2888
- Medical College of Wisconsin – Milwaukee 414-456-8261

Autopsy:

______I would accept 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 would accept an autopsy if it can help the advancement of medicine or medical education.

______I do not want an autopsy performed on me.

Part IV - Making the Document Legal

Instructions for completing Part IV:

This document must be signed and dated by you and two witnesses in each other's presence. ***The two witnesses must watch you sign, or, if you are incapable of signing or cannot hear and/or see, you may authorize another person to sign it for you.***

I agree with everything that is written in this document and I have made this document willingly. My signing of this document revokes all previous Powers of Attorneys for Health Care documents.

________________________________ ____________________

My Signature Date

If I cannot sign my name, I can ask someone to sign this document for me. I have asked the following individual, who is at least 18 years old, to sign this document on my behalf because I am unable to sign it myself.

____

Signature of authorized signer

____

Print the name of the person that I have asked to sign this document for me.

Statement of Witnesses (Witness requirements are on page 10)

I personally know the person who signed this document. I believe the person signing above (or directing someone else to sign for him or her) to be of sound mind and at least 18 years of age. I personally witnessed him or her, or his or her proxy, sign this document, and I believe that he or she did so voluntarily.
I understand that the references above to "the person signing this document" include the person who is physically unable to sign but who has asked another person to sign on his or her behalf.

Witness No. 1	**Witness No. 2**
Signature	Signature
Date	Date
Print Name	Print Name
Address	Address
City State Zip	City State Zip

ADDENDUM TO THE POWER OF ATTORNEY FOR HEALTH CARE

OF: ________________________________

____ 1. I would prefer not to be placed in a nursing home (and/or community-based residential facility) and stay in my own home unless it is absolutely necessary and all community resources have been exhausted.

____ 2. I believe that I am morally obligated to receive ordinary medical care and treatment but that extraordinary medical treatments such as ventilators, artificial hydration and nutrition, chemotherapy are not always obligatory. I believe that the burdens and benefits of receiving these treatments must be evaluated and should the burdens in terms of discomfort, pain, financial burden, or other negative impacts outweigh their benefits, they may be refused or discontinued.

____ 3. If consistent with my medical treatment, I would prefer to be treated at ________________________.

____ 4. I want all visitors to be able to visit me, unless inconsistent with my treatment.

____ 5. Be an active advocate as my Power of Attorney for Health Care agent/alternate. Do not simply give in to decisions that physicians make. Ask questions and understand proposals, challenge assumptions and be prepared to say no to care which I would not want and to demand care that I would want.

____ 6. If it is necessary to place me in a nursing home, I would prefer ________________________.

____ 7. Unless it is inconsistent with my health care, I never want to be put on a diet simply to control my weight.

____ 8. I authorize my health care agent to refuse medical tests of any kind for me, other than what is absolutely necessary to insure my comfort.

____ 9. If my prognosis is uncertain, I would agree to time-limited trials of interventions such as IV hydration, intensive care proceedings, tube feeding, etc. with the goal of regaining my ability to interact with others and function in my environment. If there is no improvement in my status after the pre-set time limit is up and/or it is determined that I am terminally ill or enduring intense and irreversible suffering (refer to pg.6 "Stopping or Not Attempting Life Prolonging Treatments), I want to have those interventions discontinued.

____ 10. If I am terminally ill and qualify for hospice, I wish to be admitted to hospice care.

____ 11. If my third choice for Health Care Agent is unable or unwilling to make these choices for *me, then my next choice for a Health Care Agent is:*

Fourth Choice (optional)
Name: ________________________ Cell Phone: ________________________
Day phone: ________________ Evening phone: ________________________
Address: ________________________ City: ________________ State: ____ Zip: ________

Signature: ________________________________ **Date:** ________________

Witness No. 1: ________________________________ **Date:** ________________

Witness No. 2: ________________________________ **Date:** ________________

Put your name at the top (e.g. ...of: John E. Smith). Initial on the line of each statement that you agree with and cross out those that you do not wish to have. The addendum is signed and witnessed at the same time that pg. 8 is signed and witnessed. ***See pg. 10 for witness requirements.***

By signing this document as a witness, I certify that at the time of execution 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 signing this document by blood, marriage, or adoption.
- Not directly financially responsible for the health care of the person signing this document.
- Not a health care provider directly serving the person signing this document.
- Not an employee (other than a social worker or chaplain) of a health care provider directly serving the person signing this document.
- Not an employee of an inpatient facility in which the person signing this document resides.
- Not aware that I am entitled to or have a claim on any portion of the estate for the person signing this document.

I'm done with it...now what?

You will need several copies of the form and they should go to the following (a copy is considered the same as the original):

1) The original should go to your primary physician or agent
2) A copy should go to any other doctor that you are seeing
3) **Two** copies should stay with you—one at home in an easily accessible place (<u>not</u> a safety deposit box or lockbox!) and one that you take with when you are traveling
4) A copy to your agent (if he/she doesn't have the original) and one for each alternate
5) A copy to any other health care provider, e.g. home health agency, hospice, nursing home, assisted living, etc.

You can also choose to give copies to other people, such as family members not named in the document or to your attorney.

It is also **very** important that you not only give copies of the document to your doctor(s) and to your agent and alternate(s), but that you sit down with them and discuss your wishes so that they are clear about what you want. It can help a great deal to have this conversation with other family members also, so they actually hear it from you.

Also, if the Power of Attorney is ever activated (that is, two doctors or a doctor and a psychologist examine you and sign a statement that you are no longer able to make medical decisions), the activation form needs to be attached to the original document and sent to <u>everyone</u> that has a copy of the document, with instructions to attach it to their copy.

As with any important document, you should review your Power of Attorney for Health Care on a yearly basis to check for any needed changes (e.g. in agent/alternates, health status, etc.) and update the document if necessary by doing a new one.