

# How to Complete This Power of Attorney for Health Care Document

## Overview

The attached power of attorney for health care document is a legal document, developed to meet the legal requirements for Wisconsin. This document provides a way for a person to create a power of attorney for health care document that will meet the basic requirements for Wisconsin. **The agent is not required to sign the document.**

This power of attorney for health care document allows you to appoint another person or persons to make your health care decisions if you become unable to make these decisions for yourself. The person (or persons) you appoint is your Health Care Agent. This document gives your Health Care 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 Health Care Agent any authority to make your financial or other business decisions.

PLEASE NOTE: Before completing this power of attorney for health care document, take time to read it carefully. There may be medical terms or phrases used that are not clear to you. You might want to complete the document with your health care provider or a trained advance care planning facilitator, who can offer help and explain anything you do not understand. If you need help completing the document, please talk with your health care provider or call Aurora Health Care at 1-888-863-5502 to be referred to a trained facilitator.

If you complete this document on your own, it is still 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 may not be fully respected because they will not be 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 document, (for instance, if you have no one you can designate as your agent) ask your health care organization or attorney for advice about alternatives.

## How to Complete This Document

This power of attorney for health care document is divided into four parts:

- Part I — Appointing a Health Care Agent
- Part II — Authority of the Health Care Agent
- Part III — Statement of Desires, Special Provisions, or Limitations
- Part IV — Making the Document Legal

## Steps to Follow:

**In each of the four parts of the attached document you will find instructions. Read and follow these instructions carefully. The basic things you must do are:**

- provide the information on page 1;**
- appoint at least one Health Care Agent on page 3;**
- indicate choices for Part II on page 5;**
- indicate choices and any written instructions you want in Part III on pages 6-8;**
- sign and date the document in front of your witnesses (two non-related adult persons; see other witness restrictions) on page 9; and**
- have your witnesses sign the document on page 9 right after witnessing your signature. Note: All three signatures must show the same date!**

If you wish to donate your body for medical science after death, you should contact the closest medical school in your state to make arrangements.

## After Completing This Document

After you complete the document, make copies to be given out as follows:

- one copy for yourself;
- one copy for each Health Care Agent appointed in the document;
- one copy for your record at your physician's office;
- one copy for your record at the hospital where you would go in an emergency;
- extra copies to share with others if you wish (loved ones, your minister/clergy/ rabbi, and your attorney).

Be sure to discuss your document with your health care provider and your Health Care Agent.

A photo or fax copy is as legally valid as an original.

## Glossary of Terms

Here are some explanations of terms that may be helpful as you complete your Power of Attorney for Health Care Document.

**Antibiotics** – Drugs used to fight infections, such as pneumonia.

**Autopsy** – examination of the body after death to determine the cause of death and changes in the body from disease.

**Cardiopulmonary Resuscitation (CPR)** – A procedure performed to restart circulation when a person’s heart has stopped beating. It involves repeated pushing on the chest (chest compressions), and pushing air into the lungs through the mouth (artificial breathing). It may also include giving drugs and electrical shocks to restore the heartbeat.

**Dialysis** – A machine used to cleanse the blood when the kidneys cannot function on their own. Dialysis can prolong life, but cannot restore kidney function.

**Feeding Tube or Artificial Nutrition** – Food and liquids provided through a special tube. The tube may be threaded through the nose into the stomach. For longer periods of feeding, a surgical procedure may be performed to place the feeding tube through the abdomen into the stomach.

**Intravenous (IV) Hydration** – A tube placed in a vein (hand, arm, or other location) that is used to give a person fluids.

**Life Prolonging Treatment** – Any medical procedure, device or medication used to keep a person alive.

**Organ/Tissue Donation** – stating that organs or tissues of the body can be used after one’s death, to replace the diseased or failed organs of another person.

**Pain and Symptom Control** – Medical treatment and nursing care that can be given to keep a person comfortable.

**Ventilator or Respirator** – A breathing machine for persons who are unable to breathe on their own. A tube is inserted through the person’s mouth or nose (intubation) into the lungs. For longer periods of time a surgical procedure places the tube through the neck into the windpipe.

**If you are mailing a copy of your document to a hospital**

**in which you have NOT been a patient,**

please include this page

and fill in your name and Social Security number.

**First & Last Name:** \_\_\_\_\_

**Social Security Number**

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**This is necessary to create a valid medical record at the hospital.**

**You do NOT need this page unless you are sending a copy of your document**

**to a hospital in which you have not been a patient.**

**Power of Attorney for Health Care for:**

**Last Name:** \_\_\_\_\_

**Maiden Name (if applicable):** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Sex:**       **Male**                       **Female**

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Copies of this document have been given to:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

## **Power of Attorney for Health Care Document**

### ***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 without your permission.

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 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 or persons whom you have specified as your Health Care Agent. 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 your Power of Attorney for Health Care, 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, this document is invalid. In such circumstances, you may not be able to rely on your designations of alternative Health Care Agents and you should execute an entirely new Power of Attorney for Health Care.

You may also use this document to make or refuse to make any anatomical gift (donation of organs or tissue) upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior document of an anatomical gift you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. You must also have your signature witnessed.

It is suggested that you keep the original of this document on file and give copies to your healthcare provider (s), each of your agents, and to whomever you want to have a copy.

**Part I — Appointing a person to make my health care decisions when I can't make my own health care decisions**

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 Wisconsin state law.

***Instructions for Completing this Part:***

When selecting someone to be your Health Care Agent, pick someone who knows you well, who 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. Note that in the event your Health Care Agent is your spouse and your marriage is annulled or you are divorced after signing this document, this document is invalid. In such circumstance, you may not be able to rely on your designations of alternative Health Care Agents and you should execute an entirely new Power of Attorney for Health Care.

Your Health Care Agent should be at least 18 years or older and should not be your health care providers or an employee of your health care provider unless they are a close relative. Space has been provided for a second and third alternate Health Care Agent.

**The person I choose as my Health Care Agent is:**

Name: \_\_\_\_\_

Day phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

**Second choice:**

Name: \_\_\_\_\_

Day phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If this Health Care Agent is unable or unwilling to make these choices for me, then my next choice for a Health Care Agent is:

**Third choice**

Name: \_\_\_\_\_

Day phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Part II — General Authority of the Health Care Agent**

I want my Health Care Agent to be able to do the following (Please cross out anything you do not want your Health Care Agent to do that is listed below):

- To make choices for me about my medical care and services, like tests, medicine, and surgery. If treatment has already been started, my Health Care Agent can keep it going or have it stopped depending upon my stated instructions or my best interests.
- To interpret any instruction I have given in this document or given in other discussions according to my Health Care Agent's understanding of my wishes and values.
- To review and release my medical records and personal files as needed for my medical care.
- To arrange for my medical care and treatment in Wisconsin or any other state, as my Health Care Agent thinks appropriate.
- To determine which health professionals and organizations provide my medical 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 drastic mental health treatment procedures for me.

## ***Instructions for Completing these Sections:***

Initial or mark the box either a “yes,” “no,” or “not applicable” box in the following three sections. If you do not initial or make a mark in any box in a section and make no clear choice, the statute in Wisconsin says your choice is considered to be “no.” This means if you do not indicate a choice, in Wisconsin only a court may make such a decision and not your Health Care Agent.

### **1. Agent authority to admit me to a nursing home or community-based residential facility for purpose of long-term care.**

*(Initial or mark one box)*

- Yes, my Health Care Agent has authority, if necessary to admit me to a nursing home or community-based residential facility for a long term stay, subject to any limits I have set forth in this document.
- No, my Health Care Agent does not have authority to admit me to a Wisconsin nursing home or a community-based residential facility for a long-term stay. *If I check “no,” I cannot be admitted to a nursing home or community-based residential facility for a long-term stay without a court order.*

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

*(Initial or mark one box)*

- Yes, my Health Care Agent has authority to have a feeding tube or I.V. hydration withheld or withdrawn from me subject to any limits I have set forth in this document.
- No, my Health Care Agent does not have authority to have a feeding tube or I.V. hydration withheld or withdrawn from me. *If I check “no,” feeding tubes or I. V. hydration cannot be withheld or withdrawn in Wisconsin without a court order.*

### **3. Agent authority to make decisions if I am pregnant.**

*(Initial or mark one box)*

- Yes, my Health Care Agent has authority to make decisions for me if I am pregnant, subject to any limits I have later set forth in this document.
- No, my Health Care Agent does not have authority to make decisions for me if I am pregnant. *If I check “no,” health care decisions cannot be made for me without a court order during my pregnancy.*
- Not applicable, because I am either a male or have reached menopause or have had a hysterectomy.

### **Part III— Statement of Desires, Special Provisions, or Limitations**

My Health Care Agent shall make decisions consistent with my stated desires, and is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my Health Care Agent and/or physician providing my medical care. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, or my Health Care Agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own health care.

#### ***Instructions for Completing this Part:***

The following instructions are optional. If you choose not to provide any instructions, your health care 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 the page.

#### **Stopping Attempts of Life Prolonging Treatments:**

*(Either initial or mark the box)*

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

#### **Pain and Symptom Control:**

*(Either initial or mark the box)*

If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable.

**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, will not stop emergency personnel from attempting CPR in an emergency. Other documents may be needed to control the actions of emergency personnel.

*(Initial or mark one box)*

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.

**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 Tissue:***

*(Initial or mark one box)*

- I wish to donate only the following organs or parts (Name the specific organs or tissue): \_\_\_\_\_
- I wish to donate any organs or tissue if I am a candidate.
- I do not want to donate any organ or tissue.

***Autopsy:***

*(Initial or mark in both the first and second choice or just one choice)*

- 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.

**Religion:**

I am of the \_\_\_\_\_ faith, and am a member of the \_\_\_\_\_ congregation, synagogue, or worship group. Phone number of congregation, synagogue, or worship group (if known): \_\_\_\_\_

Please attempt to notify them.

**Persons I Want My Agent to Include in the Decision Process:**

I ask that my Health Care Agent seek input from the following persons in my health care decisions if there is time: \_\_\_\_\_

## Part IV – Making the Document Legal

### *Instructions for Completing this Section:*

Wisconsin residents must have this document signed and dated in the presence of two witnesses.

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

\_\_\_\_\_  
My signature

\_\_\_\_\_  
Date

**If I cannot sign my name, I can ask someone to sign this document for me.**

\_\_\_\_\_  
Signature of the person who I asked to sign this document for me.

\_\_\_\_\_  
Print the name of the person who I asked to sign this document for me.

### **Statement of Witnesses**

I personally know the person who signed this document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

By signing this document as a witness, I certify that 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 that person's health care.
- not a health care provider serving the person at this time.
- not an employee (other than a social worker or chaplain) of (i) a health care provider serving the person at this time or (ii) an inpatient health care facility of which the patient is admitted or receiving treatment.
- to the best of my knowledge I am not entitled to and do not have a claim against the person's estate.

#### **Witness number 1:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

#### **Witness number 2:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

**Optional Questions:**

**You may wish to fill in an answer to the items below or to write your own thoughts here or on an additional page.**

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

**If I am Nearing My Death, I Want the Following: (List things 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:**

**Other thoughts or comments:**

*Adapted with permission from Gundersen Lutheran and provided by Aurora Health Care.*