Advance Directive
including Power of Attorney for Health Care

Overview
This legal document meets the requirements for Wisconsin, Minnesota and Iowa.* It lets you
• Name another person to make your health care decisions if you cannot make them for
  yourself.
• Write down your goals and preferences for future medical care in specific situations.
The person you name is called your health care agent. You can also name alternate health care
agents who can make decisions if the person you named first or second cannot or is not willing
to make those decisions. This document gives your agent authority to make health care decisions
on your behalf only after doctors and/or health care professionals authorized under current state
law have determined you are incapable of making health care decisions for yourself.

This document does not give your agent authority to:
• Make financial or other business decisions.
• Make certain decisions about your mental health treatment.

Read this advance directive carefully before you complete and sign it. You should discuss your
goals, values, and this advance directive with your health care agent(s). Unless you
talk with your health care agent(s), they may not know your goals and be able to follow
your instructions.

Recommendation: Make an appointment with an advance care planning facilitator for help. If
this advance directive does not meet your needs, ask your health organization or attorney about
other options.

To complete this advance directive
This advance directive is divided into four parts:
Part 1 – My health care agent
Part 2 – General authority of the health care agent
Part 3 – Statement of desires, care instructions or limits
Part 4 – Making the document legal
Follow the instructions in each of the four parts.

After you complete your advance directive
Take these steps:
• Talk to the person(s) you named as your agent(s) about your goals and preferences for
  future medical care, if you have not already. Make sure they feel able to do this important
  job for you in the future.
• Give your agent(s) a copy of this advance directive.
• Talk to the rest of your family and close friends who might be involved if you have a serious
  illness or injury. Make sure they know who your agent(s) is, and what your preferences are.
• Give a copy to your doctor and/or your health care facility. Make sure your preferences are
  understood.

*As of October 2020  The name Honoring Choices Wisconsin is used under license from the Twin Cities Medical
Foundation.
Advance Directive including Power of Attorney for Health Care

Overview

This 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 and other documentation that will meet the basic requirements for this state.

This advance directive allows you to appoint another person and alternate people to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called 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 physicians to make them. It does not give your health care agent any authority to make your financial or other business decisions. In addition, it does not give your health care agent authority to make certain decisions about your mental health treatment.

Before completing this document, take time to read it carefully. It also is very important that you discuss your views, your 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 advance directive, ask your health organization or attorney for advice about alternatives.

This is an advance directive for: (please print)

Name   Date of Birth
Telephone (Home)  (Work)   (Cell)
Address
City   State/ZIP

KEEP ORIGINAL STAPLED UNTIL READY TO SCAN/FILE


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Need help?

If you need help to complete this advance directive, contact Honoring Choices Wisconsin:

hcw@wismed.org or (866) 442-3800
Advance Directive including Power of Attorney for Health Care

For:

Name __________________________________________ Date of Birth ________________

Telephone (Cell) __________________________ (Work) __________________________
(Home) __________________________________

Address ________________________________________________________________

City________________________ State/ZIP ________________________________

I intend to give copies of this document to:

Name __________________________________________
Name __________________________________________
Name __________________________________________
Name __________________________________________
Name __________________________________________
Name __________________________________________
Name __________________________________________

Health care professional/health care facility:

Name __________________________________________
Name __________________________________________
Name __________________________________________

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Honoring Choices Rev. date: October 2020
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 or domestic partner and your marriage is annulled or you are divorced or the domestic partnership is terminated 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 doctor.
Part 1: My health care agent

If you can no longer make your own health care decisions, this advance directive names the person you authorize to make these choices for you. This person will be your health care agent. State law says your health care agent will make your health care choices for you only after doctors and/or other healthcare professionals authorized under current state law have determined you are incapable of making health care decisions. Your agent will make decisions about your medical care as you would if you were able. You and your health care agent(s) should have ongoing talks about your health and health care choices.

Choose someone who knows you well. It should be someone you trust and who respects your goals and values. This person should be able to make difficult decisions under stress. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Discuss this document and your views with the person(s) you choose to be your health care agent(s).

A health care agent must be at least 18 years old. Your health care agent may not be one of your health care providers or an employee of your health care provider, unless he or she is a relative.

The person I choose as my health care agent is:

Name ____________________________ Relationship ____________________________

Telephone (Cell) ___________________ (Work) ___________________ (Home) ___________________

Address ______________________________________________________

City ____________________________ State/ZIP ________________________

If that person is unable or unwilling to make decisions for me, then my next choice is:

Second choice:

Name ____________________________ Relationship ____________________________

Telephone (Cell) ___________________ (Work) ___________________ (Home) ___________________

Address ______________________________________________________

City ____________________________ State/ZIP ________________________

If that person is unable or unwilling to make decisions for me, then my next choice is:

Third choice:

Name ____________________________ Relationship ____________________________

Telephone (Cell) ___________________ (Work) ___________________ (Home) ___________________

Address ______________________________________________________

City ____________________________ State/ZIP ________________________

☐ I do not have a health care agent. Instead, I want Part 3 of this document to guide my health care.
Part 2: General authority of the health care agent

To complete this part:
Draw a line through anything in the box below you do not want your health care agent to do. For example, it should look like this: Decide on

I want my health care agent to be able to:

- Decide on tests, medicine, surgery and other medical care. If treatment has started, my agent can keep it going or stop it, based on my instructions or my best interests.
- Interpret my instructions based on what he or she knows of my preferences and values.
- Arrange for my medical care and treatment in Wisconsin or any other state.
- Decide whether organs or tissues (anatomical gifts) can be donated after my death according to my preferences and values.

Limits on mental health treatment in Wisconsin

Wisconsin law says my health care agent may not admit or commit me to an inpatient facility for mental health treatment. This means that in Wisconsin, my agent cannot admit me to:

- an institution for mental diseases
- an intermediate care facility for people with an intellectual disability, or
- a state treatment facility for mental health.

My health care agent may not agree to any drastic mental health treatments for me. These treatments include experimental mental health research, brain surgery, or electroshock therapy.
To complete the next three questions:
Initial or check the box beside the one statement in each section you agree with.
In Wisconsin, if you do not mark any box in a section, or you choose “no,” only a court can make the decision and not your health care agent.

1. Agent authority to make the decision to admit me to a nursing home or community-based residential facility for long-term care.
   Note: Your health care agent has the authority to admit you to a nursing home or care facility (community-based residential facility) for a short-term stay. For example, you might need care to recover after surgery and you expect to go home.

If I need long-term care for any reason, then:

☐ Yes, my agent can make the decision to admit me to a nursing home or community-based residential facility for a long-term stay.

☐ No, my agent cannot make the decision to admit me to a nursing home or community-based residential facility for a long-term stay.

In Wisconsin, choosing “no” or leaving this section blank means I cannot be admitted to a Wisconsin long-term care facility without a court order.

2. Agent authority to make the decision to refuse or have removed a feeding tube and/or IV fluids.

☐ Yes, my agent can make the decision to refuse or stop tube feedings and/or IV fluids.

☐ No, my agent cannot make the decision to refuse or stop tube feedings and/or IV fluids.

In Wisconsin, choosing “no” or leaving this section blank means feeding tubes and IV fluids cannot be refused or stopped without a court order.

3. Agent authority to make health care decisions during pregnancy.

☐ Yes, my agent can make health care decisions for me if I am pregnant.

☐ No, my agent cannot make health care decisions if I am pregnant.

☐ This does not apply to me.

In Wisconsin, choosing “no” or leaving this section blank means health care decisions cannot be made for me while I am pregnant without a court order.
Part 3: Statement of desires, care instructions or limits

Part 3 allows you to make your preferences clear. Your health care agent and your doctors will refer to this section as they care for you. If you did not name a health care agent or if your health care agent cannot be reached, you can direct your care with the choices you make below. You should talk with your health care agent about the kind of care you want, even if you don’t make choices in this section.

You are not required to complete this part of the document.

To complete this part:

Initial or check the box beside the one statement you agree with. You may add other specific care instructions on page 7.

1. Treatments that may prolong life if I am in this situation.

If I am sick or injured and my doctors believe there is little chance I will recover the ability to know who I am, who my family and friends are, or where I am, this is my choice:

- I want to refuse or stop all treatments. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, antibiotics, or fluids given to me through an IV, treatments for chronic medical conditions, or other medications.

- I want to receive all treatments to keep me alive, unless my doctor determines the treatments would harm me more than help me.

With either choice, I understand I will be kept clean and comfortable. I will continue to receive pain and comfort medicines, and food and fluids by mouth if I can swallow safely.

2. Cardiopulmonary resuscitation (CPR).

Based on my current health, this is my choice about CPR if my heart or breathing stops.

- I want CPR attempted unless my doctor determines:
  - I have a medical condition and no reasonable chance of survival with CPR, OR
  - CPR would harm me more than help me.

- I do not want CPR. Let me die a natural death.

If you do not want emergency personnel to give you CPR, you will need to talk to your doctor about other documents you need.
Specific care instructions to meet my goals and preferences in certain situations:

Comfort preferences: These things are important to me for comfort (for example, favorite music, warm blankets, best positioning in bed).

Including others when making decisions about my care: (If there is time, try to include these people in my care decisions.)

If I am near death and cannot communicate, I want to give my friends and family these personal messages:
**If I am near death, things I would want:** (For example, favorite music, rituals, dim lighting, a visit from the hospital chaplain or someone from my faith community.)

To complete this part:
Initial or check the box beside the statement you agree with.

After my death, these are some of my preferences:

1. **Donation of my organs or tissue (anatomical gifts)**

   Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves.

   - A. I do not wish to donate any part of my body.
   - B. After I die, I wish to donate any parts of my body that may help others.*
   - C. After I die, I wish to donate only these organs and tissue:* ________________

*If you checked B or C, register in your state at [www.DonateLife.net](http://www.DonateLife.net) to make your preferences legal.

2. **Autopsy preference**

   **Initial or check one box OR both B and C.**

   - A. I do not wish to have an autopsy.
   - B. I would accept an autopsy if it can help my relatives and/or loved ones understand the cause of my death or if the findings may help them make their own health care choices.
   - C. I would accept an autopsy if it can help advance medical knowledge or medical education.
Part 4: Making the document legal

In Wisconsin: This document must be signed and dated in the presence of two witnesses who meet the qualifications explained below. A notary public cannot be used instead of the two witnesses.

In Minnesota or Iowa: This document must be signed and dated either in the presence of two witnesses who meet the qualifications explained below OR in the presence of a notary public.

My signature and date
I am of sound mind. I agree with everything written in this document. I have completed this document of my free will.

Date: ________________ My signature __________________________

If I cannot sign my name, I ask (print name) ____________________________ to sign for me.

Signature of the person I asked to sign for me ____________________________

Statement of witnesses

A. By signing this document as a witness, I certify I am:
   • At least 18 years old.
   • Not related by blood, marriage, domestic partnership, or adoption to the person signing this document.
   • Not a health care agent appointed by the person signing this document.
   • Not directly financially responsible for this person’s health care.
   • Not a health care provider directly serving the person at this time.
   • Not an employee of a health care provider directly serving the person at this time.
      In Wisconsin, social workers and chaplains may serve as witnesses even if employed by the health care provider.
   • Not aware that I am entitled to or have a claim against the person’s estate.

B. I know this to be the person identified in the document. I believe this person to be of sound mind and at least 18 years old. I personally witnessed this person sign this document, and I believe that this person did so voluntarily.

Witness Number One:
Date ________________ Signature __________________________
Print name ____________________________
Address ____________________________
City ____________________________ State/ZIP ____________________________

Witness Number Two:
Date ________________ Signature __________________________
Print name ____________________________
Address ____________________________
City ____________________________ State/ZIP ____________________________
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- Name:
- Date of Birth:
- Telephone (Home):
- Telephone (Work):
- Telephone (Cell):
- Address:
- City:
- State/ZIP:

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Instructions for notarization (Minnesota or Iowa only)

Residents of Iowa and Minnesota may have the document signed and stamped by a notary public authorized in their state instead of two witnesses.

Notary Public:

In the state of Minnesota/Iowa (circle one), County of ________________________________.

In my presence on _______________ (date), ________________________________ (name) acknowledged his or her signature on this document or authorized the person signing this document to sign on his or her behalf. I am not named as a health care agent or alternate health care agent in this document.

________________________________________________________ Notary stamp (required):

Signature of notary

________________________________________________________

Title (and rank)

My commission expires (date): ________________________________