WISCONSIN
Advance Directive
Planning for Important Health Care Decisions

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

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

It's About How You LIVE

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

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
   - Instructions for preparing your advance directive, please read all the instructions.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers, and/or faith leaders so that the form is available in the event of an emergency.

5. 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.

6. You may also want to save a copy of your form in Google Health, or another online medical records management 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. You can read more about Google Health at http://www.caringinfo.org/googlehealth.

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 determines that you are no longer able to make or communicate 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 determines that you are no longer able to make or communicate your health care decisions, and 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 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 an 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; 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.

PART I. 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.

NOTICE

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

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

NOTICE (CONTINUED)

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

PART II. WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE

PRINT THE DATE

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

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME, ADDRESS AND DATE OF BIRTH

I, _____
(print name)

_____
(address)

_____
(date of birth)

being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate

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

_____
(print name)

_____
(address and telephone number)

to be my health care agent for the purpose of making health care decisions on my behalf.

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

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

_____
(print name)

_____
(address)

_____
(telephone number)

to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the mentally retarded, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or other drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community-based residential facility for short -term stays for recuperative care or respite care.

If I have initialed "Yes" in the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have initialed "No" to the following, my health care agent may not so admit me:

INITIAL TO INDICATE YOUR HEALTH CARE AGENT'S ADMISSION POWERS

1. A nursing home: Yes ____ No ____
2. A community-based residential facility: Yes ____ No ____

If I have not initialed either "Yes" or "No" immediately above, my health care agent may only admit me for short-term stays for recuperative care or respite care.

PROVISION OF A FEEDING TUBE

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

If I have initialed "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort.

If I have initialed "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.
Withhold or withdraw a feeding tube: Yes ____ No ____

If I have not initialed either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withdrawn from me.

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. DECLARATIONS TO PHYSICIANS

PRINT YOUR NAME

I, _____,
(print name)
being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

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:

_____ _____

_____ _____

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

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR NAME

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 _____

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ANATOMICAL GIFTS (OPTIONAL)

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

SIGN AND PRINT YOUR NAME THE DATE

ANATOMICAL GIFTS (OPTIONAL)

Upon my death:

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

_____
(specify the organs or parts)

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

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

_____ _____
(signature of principal) (date)

_____
(printed name of principal)

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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 healthcare. 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 Google Health, or another online medical records management 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. You can read more about Google Health at http://www.caringinfo.org/googlehealth.

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. **Caring Connections does not distribute these forms.**