Wisconsin Living Will Declaration

Wis. Stat. § 154.03

I, _____, 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.

1. If I have a **TERMINAL CONDITION,** as determined by 2 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 checked either box, feeding tubes will be used.

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 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 checked either box, life-sustaining procedures will be used.

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 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 used if I am in a persistent vegetative state.

If you have not checked 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.

ATTENTION: You and the 2 witnesses must sign the document at the same time.

Signed _____ Date _____

Address _____ Date of Birth _____

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness Signature _____ Date Signed _____

Print Name _____

Witness Signature _____ Date Signed _____

Print Name _____

DIRECTIVES TO ATTENDING PHYSICIAN

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when 2 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 that withholding or withdrawing 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 make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

* * * * *

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:

Wisconsin Power of Attorney for Healthcare

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

CREATION OF POWER OF ATTORNEY FOR HEALTHCARE

I, _____
(print name)

_____
(address)

_____
(date of birth)

being of sound mind, intend by this document to create a power of attorney for healthcare. My executing this power of attorney for health c a re is voluntary. Despite the creation of this power of attorney for healthcare, I expect to be fully informed about and allowed to participate in any healthcare decision for me, to the extent that I am able. For the purposes of this document, "healthcare 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 HEALTHCARE AGENT

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

_____
(print name)

_____
(address and telephone number)

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

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

_____
(print name)

_____
(address and telephone number)

to be my alternate healthcare agent for the purpose of making health care decisions on my behalf. Neither my healthcare agent nor my alternate healthcare agent whom I have designated is my healthcare provider, an employee of my healthcare provider, an employee of a healthcare 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 healthcare 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 healthcare provider to obtain the healthcare decision of my healthcare agent, if I need treatment, for all of my health c a re and treatment. I have discussed my desires thoroughly with my healthcare agent and believe that he or she understands my philosophy regarding the healthcare decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my healthcare agent under this document.

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

LIMITATIONS ON MENTAL HEALTH TREATMENT

My healthcare 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 healthcare 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 healthcare 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 checked "Yes" to the following, my healthcare agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my healthcare agent may not so admit me:
1. A nursing home: Yes ☐ No ☐
2. A community-based residential facility: Yes ☐ No ☐

If I have not checked 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 I have checked "Yes" to the following, my healthcare 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 checked "No" to the following, my healthcare agent may not have a feeding tube withheld or withdrawn from me.

My healthcare 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 checked either "Yes" or "No" immediately above, my healthcare agent may not have a feeding tube withdrawn from me.

HEALTHCARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my healthcare agent may make healthcare decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my healthcare agent may not make healthcare decisions for me if my healthcare agent knows I am pregnant.
Healthcare decision if I am pregnant: Yes ☐ No ☐

If I have not checked either "Yes" or "No" immediately above, my healthcare agent may not make healthcare decisions for me if my healthcare agent knows I am pregnant.

STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

In exercising authority under this document, my healthcare 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:_____

_____

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my healthcare 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.

_____
(The principal and the witnesses all must sign the document at the same time.)

SIGNATURE OF PRINCIPAL
(PERSON CREATING THE POWER OF ATTORNEY FOR HEALTHCARE)
Signature _____ Date _____
(The signing of this document by the principal revokes all previous powers of attorney for healthcare 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 healthcare 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 healthcare. I am not a healthcare provider who is serving the principal at this time, an employee of the healthcare provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient healthcare facility in which the declarant is a patient. I am not the principal's healthcare 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:
(print) Name _____ Date _____
Address _____
Signature _____

Witness No. 2:
(print) Name _____ Date _____
Address _____
Signature _____

STATEMENT OF HEALTHCARE AGENT AND ALTERNATE HEALTHCARE AGENT
I understand that _____
(name of principal)
has designated me to be his or her healthcare agent or alternate healthcare agent if he or she is ever found to have incapacity and unable to make healthcare decisions himself or herself. _____ has discussed his or her desires regarding healthcare decisions with me. *(name of principal)*

Agent's signature _____
Address _____

Alternate agent's signature _____
Address _____

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.
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)*