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Legal Forms & Services

FirstName LastName

WISCONSIN
HEALTH CARE DIRECTIVE

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive in Wisconsin

After printing your document, you will need to finalize it. Below are the steps:

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

This document includes the following:

Power of attorney for health care designating a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.

Declaration to health care professionals (living will) with health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

POWER OF ATTORNEY FOR HEALTH CARE

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 PHYSICIAN OR OTHER PRIMARY CARE PROVIDER.

Document made this _____ day of _____, _____

I, FirstName LastName, 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.

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 the following individual to be my health care agent for the purpose of making health care decisions on my behalf:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address
City, Wisconsin 11111
Phone: 1111111111
Email: emailaddress@email.com

If my first choice is ever unable or unwilling to do so, I hereby designate the following individual to be my alternate health care agent for the purpose of making health care decisions on my behalf:

Name: FirstName LastName
Relationship: Son
Address: 222 Street Address
City, Wisconsin 11111
Phone: 1111111111
Email: emailaddress@email.com

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, nurse practitioner, or physician assistant 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 am ever incapacitated, 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 the health care decision on what is believed 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 persons with an intellectual disability, 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.

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

- 1. A nursing home Yes No

- 2. A community-based residential facility Yes No No

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

PROVISION OF A FEEDING TUBE

If I have checked “Yes” to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician, physician assistant, or nurse practitioner 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 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 checked either “Yes” or “No” immediately above, my health care agent may not have a feeding tube withdrawn from me.

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):

I do not wish to leave a statement of desires, special provisions, or limitations at this time.

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

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

SIGNATURE OF PRINCIPAL

(person creating the power of attorney for health care)

Signature. _____

Date. _____

(The signing of this document by the principal revokes all previous powers of attorney for health care documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe them to be of sound mind and at least 18 years of age. I believe that their 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, am not the domestic partner of the principal, 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:

Name Printed

Date

Address

Signature

Witness No. 2:

Name Printed

Date

Address

Signature

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that, _____ (name of principal) has designated me to be his/her/their health care agent or alternate health care agent if they are ever found to have incapacity and unable to make health care decisions themselves. _____ (name of principal) has discussed their desires regarding health care decisions with me.

Agent's signature

Address

Alternate's signature

Address

**DECLARATION TO HEALTH CARE PROFESSIONALS
(LIVING WILL)**

I, FirstName LastName, 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, physician assistant, or advanced practice registered nurse 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 a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, 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 a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, 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 a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, 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.

**DIRECTIVES TO ATTENDING PHYSICIAN, PHYSICIAN ASSISTANT, OR
ADVANCED PRACTICE REGISTERED NURSE**

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when a physician and another physician, physician assistant, or advanced practice registered nurse, one of whom is the attending health care professional, 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, physician assistant, or advanced practice registered nurse 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.

SIGNATURES

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

Signature

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