

Health Care Directive for Wisconsin

Introduction

I have completed this Health Care Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

NOTE: This document does not apply to intrusive mental health treatments, defined as electroconvulsive therapy or neuroleptic medications.

Any advance directive document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

My telephone numbers: (home) _____ (cell) _____

My initials here indicate a professional medical interpreter helped me complete this document.

Part 1: My Health Care Agent

If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the following person to communicate my wishes and make my health care decisions. My Health Care Agent must:

- Follow my health care instructions in this document.
- Follow any other health care instructions I have given to him or her.
- Make decisions according to what my agent believes I would want in these circumstances.

My Primary (main) Health Care Agent is:

Name: _____ Relationship: _____

Telephone numbers: (H) _____ (C) _____ (W) _____

Full address: _____

If I cancel my primary agent's authority, or if my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate Health Care Agent.

My Alternate Health Care Agent is:

Name: _____ Relationship: _____

Telephone numbers: (H) _____ (C) _____ (W) _____

Full address: _____

This is the directive of (name): _____ **Date Completed:** _____

Powers of my Health Care Agent:

If I am unable to communicate and/or lack the capacity to manage my own health care decisions, this document becomes effective and will grant me Health Care Agent the power to:

- A. Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, taking out or not putting in tube feedings, and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.
- B. Interpret any instruction in this document based on his or her understanding of my wishes, values and beliefs.
- C. Request, receive, and review any information regarding my physical or mental health, including "protected health information" as defined by the Federal Health Insurance Portability and Accountability Act (HIPAA). I designate my agent as my "personal representative" with all the authority granted to such under HIPAA and applicable state and federal laws.
- D. Arrange for my health care and treatment in Wisconsin or other state or location he or she thinks is appropriate.
- E. Make decisions about organ and tissue donation and autopsy according to my instructions in Part 2 of this document.

Limits on Mental Health Treatment:

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.

Comments or limits on the above:

Additional powers of my Health Care Agent:

My initials below indicate I also authorize my Health Care Agent to:

In the event I am pregnant, decide whether to try to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences and/or instructions.

My agent can make the decision to admit me to a nursing home or community-based residential facility for a long-term stay. **In Wisconsin**, leaving this section blank means I cannot be admitted to a Wisconsin long-term care facility without a court order.

This is the directive of (name): _____ ***Date Completed:*** _____

Notice to Person Making their Health Care Directive

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 your 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.

This is the directive of (name): _____ *Date Completed:* _____

Part 2: My Health Care Instructions

My choices and preferences for health care are as follows. I ask my Health Care Agent to communicate these choices, and my health care team to honor them, if I cannot communicate or make my own choices. **I have initialed a box below for the option I prefer for each situation.**

NOTE: *You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or according to what my agent believes I would want done in these circumstances..*

1. Cardiopulmonary Resuscitation: Instructions for the Present

This decision refers to a treatment choice I am making today based on my current health. Item 3 below (**Treatments to Prolong My Life: A Decision for the Future**) indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization. I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases or impaired functioning, or both. I understand that recovery from CPR can be painful and difficult.

Therefore:

I want CPR attempted if my heart or breathing stops.

or

I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed; for example:

- I have an incurable illness or injury and am dying
- I have no reasonable chance of survival if my heart or breathing stops
- I have little chance of long-term survival if my heart or breathing stops and CPR would cause significant suffering

then my agent or I (if I am able) should discuss CPR with my health care team. My choices in **Section 2: Treatment Preferences** and **Section 3: Treatments to Prolong My Life** below should be considered when making this decision.

or

I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand if I choose this option I should see my health care provider about writing a Do Not Resuscitate (DNR) order.

This is the directive of (name): _____ **Date Completed:** _____

2. Treatment Instructions: My Health Condition

My treatment choices for my specific health condition(s) are written here. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

My initials here indicate additional documents are attached:

3. Treatments to Prolong My Life: Instructions for the Future

If I can no longer make decisions for myself, and my health care team and agent believe I will not recover my ability to know who I am, I want:

NOTE: With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

To **stop or withhold all treatments** that extend my life. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics. This may include hospice and/or palliative care for purposes of comfort.

or

All treatments recommended by my health care team. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics. I want treatments to continue until my health care team and agent agree such treatments are harmful or no longer helpful.

Comments or directions to my health care team:

This is the directive of (name): _____ **Date Completed:** _____

4. Organ donation

I want to donate my eyes, tissues and/or organs, if able. My specific wishes (if any) are:

or

I do not want to donate my eyes, tissues and/or organs.

or

My Health Care Agent can decide.

*If you checked that you would like to donate your organs, register in your state at www.DonateLife.net to make your preferences known.

5. Autopsy

My Health Care Agent may request an autopsy if the autopsy can help others understand the cause of my death or help with future health care decisions.

or

I do not want an autopsy unless required by law.

6. Comments or directions to my health care team:

You may use this space to write any additional instructions or messages to your health care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.

This is the directive of (name): _____ ***Date Completed:*** _____

7. If I need help to remain living independently, here are my wishes:

8. If I need comfort care which may include hospice, here are my wishes:

My initials here indicate additional documents are attached:

This is the directive of (name): _____ ***Date Completed:*** _____

Part 3: My Hopes and Wishes

I want my loved ones to know my following thoughts and feelings:

The things that make life most worth living to me are:

My beliefs about when life would be no longer worth living:

What it would mean for me to be ready to die:

My thoughts and feelings about how and where I would like to die:

If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (rituals, prayers, music, etc.):

Religious affiliation: I am of the _____ faith, and am a member of _____ faith community in (city) _____. Please notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like my funeral to include, if possible, the following (people, music, rituals, etc.):

Other wishes and instructions:

My initials here indicate additional documents are attached:

This is the directive of (name): _____ **Date Completed:** _____

Part 4: Legal Authority

NOTE: Under Wisconsin law, two witnesses must verify your signature and the date. Please see below in "Statement of Witnesses" for requirements.

I have made this document willingly. I am thinking clearly. This document states my wishes about my future health care decisions:

Signature: _____ **Date:** _____

If I cannot sign my name, I ask the following person to sign for me:

Printed Name **Signature** (of person asked to sign)

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 servicing 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 1:

Signature _____

Date: _____

Print name

Address (optional)

Witness 2:

Signature _____

Date: _____

Print name

Address (optional)

This is the directive of (name): _____ **Date Completed:** _____

Part 5: Next Steps

Now that I have completed my Health Care Directive, I will also:

- Make sure my primary and alternate Health Care Agents feel able to do this important job for me in the future.
- Give my primary and alternate Health Care Agents a copy of this completed Health Care Directive.
- Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Health Care Agent is, and what my wishes are.
- Give a copy of this completed Health Care Directive to my doctor and other health care providers and make sure they understood and will follow my wishes.
- Keep a copy of my Health Care Directive where it can be easily found.
- Take a copy of my Health Care Directive any time I am admitted to a health care facility, and ask that it be placed in my medical record.
- **Review my health care wishes every time I have a physical exam or whenever any of the "Five Ds" occur:**

Decade when I start each new decade of my life.

Death when I experience the death of a loved one.

Divorce when I experience a divorce or other major family change.

***In Wisconsin,** I must file a new Health Care Directive if I become divorced from my chosen health care agent, even if I wish my former spouse to serve as my agent; a Directive that identified a spouse as agent is made invalid by a divorce.

Diagnosis when I am diagnosed with a serious health condition.

Decline when I experience a significant decline or deterioration of an existing health condition, especially when I am unable to live on my own.

Copies of this document have been given to:

Primary (main) Health Care Agent (listed on page 1 of this document)

Name: _____ Telephone: _____

Alternate Health Care Agent (listed on page 1 of this document)

Name: _____ Telephone: _____

Health Care Provider/Clinic

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

If my wishes change, I will fill out a new Health Care Directive. I will give copies of the new document to everyone who has copies of my previous Health Care Directive. I will tell them to destroy the previous version.

This is the directive of (name): _____ ***Date Completed:*** _____