Wisconsin Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will (Declaration to Physicians)
[ ] Selection of Health Care Agent (Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Declaration to Physicians)

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

If I have a TERMINAL CONDITION, as determined by two (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 **(initial one):**

[ ] YES, I DO 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.)

If I am in a PERSISTENT VEGETATIVE STATE, as determined by two (2) physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures **(initial one):**

[ ] YES, I DO 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.)

If I am in a PERSISTENT VEGETATIVE STATE, as determined by two (2) physicians who have personally examined me, the following are my directions regarding the use of feeding tubes
(Initial one):

[ ] YES, I DO 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 initialed either box, feeding tubes will be used.)

Selection of Health Care Agent (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 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, directing another person to destroy it in your presence, signing a written and dated statement, or stating that it is revoked in the presence of two (2) 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. 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 anatomical 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.

I, 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.

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate _____ (name), _____ (address), to be my health care agent for the purpose of making health care decisions on my behalf.

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent

_____ (name of individual you choose as alternate agent)

_____ (address)

The health care agent (or alternate) named above is not 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 two (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.

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.

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.

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" to 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 one):**

(1) A nursing home: YES [ ] **OR** NO [ ]
(2) A community-based residential facility: YES [ ] **OR** 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.)

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 **(initial one)**:

Withhold or withdraw a feeding tube: YES [ ] **OR** 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 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 **(initial one):**

Health care decision if I am pregnant: YES [ ] **OR** 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.)

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 **(insert desires, provisions, or limitations):**

Subject to any limitations in this document, my health care agent has the authority to do all of the following: (1) Request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records, (2) Execute on my behalf any documents that may be required in order to obtain this information, and (3) Consent to the disclosure of this information.

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes t**hat I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will (Declaration to Physicians)
[ ] Selection of Health Care Agent (Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care:

Signature _____ Date _____

Signature of Alternate _____Date _____