POWER OF ATTORNEY FOR HEALTH CARE

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

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, _____

_____

_____

_____

(print name, address, and 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 name, address and telephone number) to be my health care agent for the purpose of making health care 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 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, 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 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 persons with 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 ☐

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 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 practioner 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.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "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 checked "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 checked 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 any specific desires, provisions or limitations that I wish to state (add more items if needed):

1. _____

2. _____

3. _____

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 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, domestic partnership, 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 Number 1

(Print) Name _____ Date _____

Address _____

Signature _____

Witness Number 2

(Print) Name _____ 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 or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself

_____(name of principal) has discussed his or her desires regarding health care decisions with me.

Agent's Signature _____

Address _____

Alternate's Signature _____

Address _____

Failure to execute a power of attorney for health care document under chapter 155 of the Wisconsin Statutes creates no presumption about the intent of any individual with regard to his or her health care decisions. This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.

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 _____ Date _____