WISCONSIN

EDUCATION

Health Care Directive

Making Your Health Care Choices Known

Allina Health

Wisconsin version

My Health Care Directive

My health care directive was created to guide my care circle (family, friends or others close to me) and health care agent(s) to make health care decisions on my behalf if illness or injury prevents me from deciding or communicating them myself at the time of care.

I understand that it is my responsibility to talk about my wishes, goals and values with my health care provider, health care agent(s) and care circle. This will help them understand my wishes, goals and values to the best of their ability and help my health care agent make decisions for me that are in line with my health care choices.

I understand that my health care agent and my health care provider(s) may not be able to honor my wishes, goals and values in every circumstance.

I created this document with much thought.

Any health care directive document created before this is no longer valid.

My legal name: _____

My date of birth: _____

My address: _____

My telephone number: _____

My cell phone number: _____

NAME, DOB, MRN

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Power of Attorney for Health Care Document

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 would 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 who 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, this person 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. <u>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.</u>

You may also use this document to make or refuse to make any 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 you may have made. You may revoke or change any anatomical gift that you make in 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 health care provider.

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Part 1: My Health Care Agent

I have chosen a health care agent to speak for me if:

- I am unable to communicate my wishes, goals and values, and health care decisions due to illness or injury

  or

- my health care providers have determined I am not able to make my own health care decisions.

When choosing a health care agent, I have considered that person's ability to willingly make decisions based on my choices. I trust this person to follow my wishes, goals and values under stress.

I understand that my health care agent must be 18 years of age or older.

Note: If the person you choose to be your health care agent is a health care provider giving care to you now or possibly in the future, you should **not** select this person as your health care agent unless the person is related to you by blood, marriage, registered domestic partnership or adoption.

My primary (main) health care agent is:

Name: _____

Relationship: _____

Address: _____

Telephone (Home) _____ (Cell) _____ (Work) _____

Alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent is not available or willing to serve as my health care agent:

Name: _____

Relationship: _____

Address: _____

Telephone (Home) _____ (Cell) _____ (Work) _____

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Additional alternate health care agents

Note: You may leave this page blank.

2nd alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent and my first alternate health care agent are not available or willing to serve as my health care agent:

Name: _____

Relationship: _____

Address: _____

Telephone (Home) _____ (Cell) _____ (Work) _____

3rd alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent and other alternate health care agents are not available or willing to serve as my health care agent:

Name: _____

Relationship: _____

Address: _____

Telephone (Home) _____ (Cell) _____ (Work) _____

4th alternate health care agent

I choose this person as my alternate health care agent if my primary health care agent and other alternate health care agents are not available or willing to serve as my health care agent:

Name: _____

Relationship: _____

Address: _____

Telephone (Home) _____ (Cell) _____ (Work) _____

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Powers of my health care agent

My health care agent automatically has all of the following powers when I am unable to make my own health care decisions at the time I am receiving care:

- Make decisions about my health care, including decisions to start, stop or change treatments for me. This includes decisions about tests, medicine, surgery, and other decisions about treatments including mental health treatments or medicines, except as noted in the "limitations" section on page 7. If treatment has already begun, my health care agent can continue or stop it based on verbal and/or written instructions.
- Interpret any instructions in this document according to my health care agent's understanding of my wishes, goals and values.
- Review and release my medical records, health information and other personal records as needed for my health care as a personal representative under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state law.
- Arrange for my health care and treatment in any state or location my health care agent thinks is appropriate. (See page 6.)
- Decide which health care providers and organizations provide my care and treatment.

Note: Your health care agent cannot make decisions about your finances. Consider talking with a lawyer about filling out a Financial Power of Attorney document if you would like to make sure you give someone power to make financial decisions or complete financial transactions on your behalf.

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Additional powers of my health care agent

If I want my health care agent to have any of the following powers, **I have initialed** the box(es) below.

Note: If you do not initial a box in sections 1, 2 and 3, your choice will be understood to be "no." This means if you do not make a choice, your health care agent will not be able to make these decisions, and a court order will be required to allow you to receive certain care and services as described below according to Wisconsin law.

1. Admission to a nursing home or community-based residential facility

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.

My health care agent's authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care is as follows:

☐ **Yes,** my health care agent has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay. This authority is subject to any limits I set in the document and is also not in effect if I am diagnosed as developmentally disabled or as having a mental illness at the time of the proposed admission.

☐ **No,** my health care agent does not have authority to admit me to a nursing home or community-based residential facility for a long-term stay.

I understand that I must choose "yes" if I want my health care agent to be able to admit me to a long-term care facility for a long-term stay without need of a court order.

2. Withholding or withdrawal of feeding tube

☐ **Yes,** my health care agent has authority to have a feeding tube withheld or withdrawn from me, unless my health care provider advises that, using professional judgment, the withholding or withdrawing will cause me pain or discomfort. This is subject to any limits I set in this document.

Note: You will continue to be offered pain and comfort medicines as well as food and liquids by mouth if you are able to swallow.

☐ **No,** my health care agent does not have authority to have a feeding tube withheld or withdrawn from me.

I understand that I must choose "yes" if I want my health care agent to be able to consent to having a feeding tube withdrawn or withheld from me without a court order.

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3. Health care decisions during pregnancy

☐ **Yes,** my health care agent has authority to make health care decisions for me if I am pregnant. This is subject to any limits I set in this document.

☐ **No,** my health care agent does not have authority to make health care decisions for me if I am pregnant.

I understand that I must choose "yes" if I want my health care agent to be able to make health care decisions for me if I am pregnant without a court order.

☐ **Does not apply.** (Use this choice only if not physically capable of becoming pregnant.)

4. Decisions about the care of my body after death

☐ **Yes,** my health care agent has authority to make decision about the care of my body after death.

☐ **No,** my health care agent does not have authority to make decisions about the care of my body after death.

5. Continuing as health care agent if relationship ends

☐ **Yes,** my health care agent has authority to continue as my health care agent even if our marriage or domestic partnership is legally ending or has been ended.

☐ **No,** my health care agent does not have authority to continue as my health care agent even if our marriage or domestic partnership is legally ending or has been ended.

Limitations of my health care agent's powers

According to Wisconsin law, 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 on me.

If I want to limit my health care agent's authority on any other decisions or actions they may take, I have written them below.

_____

_____

_____

_____

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Part 2: My Health Care Instructions

My choices for my health care are as follows. I ask my health care agent to represent these choices, and my health care providers to honor them if I can't communicate or make my own decisions.

Note: This document gives your health care agent authority to make decisions only when:

- your health care providers determine you are not able to make your own health care decisions
- you have requested that your health care agent make decisions for you even if you are able to decide or communicate yourself.

Cardiopulmonary resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions (forceful pushing on the chest to make the blood circulate), medicines, electrical shocks, a breathing tube and a hospital stay.

I understand that:

- CPR can save a life but it does not always work
- CPR does not work as well for people who have chronic (long-term) diseases
- CPR may result in injuries and recovery from CPR can be painful and difficult.

I have initialed the option I prefer for this situation.

My choice about CPR

☐ **I want CPR** attempted if my heart or breathing stops in all circumstances.

☐ **I want CPR** attempted if my heart or breathing stops **except when** my health care provider has determined that I have little or no reasonable chance of survival even with CPR.

☐ **I do not want CPR** attempted if my heart or breathing stops. I prefer a natural death. If I choose this option, I should talk with my health care provider.

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Treatments to extend my life

If my health care providers determine I am in a vegetative state, or that I have a permanent brain injury that means it is very likely I will not regain consciousness or recover my ability to know who I am, I choose the following.

Note: With any choice, you will continue to be offered pain medicines and care to help you be comfortable (comfort measures) as well as food and liquids by mouth if you are able to swallow.

I have initialed the option I prefer for this situation.

My choice is:

☐ **I would want to stop or withhold all treatments** that are extending my life at this time. This includes, but is not limited to, tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), CPR and antibiotics (medicines).

☐ **I would want all the treatments** recommended by my health care team until they agree that such treatments are harmful and no longer helpful. This includes, but is not limited to, tube feedings, IV fluids, respirator/ventilator, CPR and antibiotics.

☐ **I would want to receive limited treatment.** I would want to receive certain types of care in certain circumstances, as I've written below. For example, you may write that you want to live on life support until all of your care circle has arrived.

_____

_____

_____

_____

_____

_____

_____

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Terminal illness

A terminal illness is an active and worsening condition that can't be cured and is expected to lead to death.

Note: With any choice, you will continue to be offered pain medicines and care to help you be comfortable (comfort measures) as well as food and liquids by mouth if you are able to swallow.

I have initialed the option I prefer for this situation.

If I have a terminal illness, my choice is:

☐ **I would want to stop or withhold all treatments** that are extending my life. This includes, but is not limited to, tube feedings, IV fluids, respirator/ventilator, CPR and antibiotics.

☐ **I would want all the treatments** recommended by my health care team until they agree that such treatments are harmful and no longer helpful. This includes, but is not limited to, tube feedings, IV fluids, respirator/ventilator, CPR and antibiotics.

☐ **I would want to receive limited treatment.** I would want to receive certain types of care in certain situations, as I've written below. For example, you may write that you want to have antibiotics to treat infections.

_____

_____

_____

_____

Other treatment choices (optional)

Note: Use this space to write any treatment choices you may have for your specific condition. For example, if you have diabetes you may write your thoughts and wishes on dialysis. You may leave this space blank.

_____

_____

_____

Note: Please sign and date any additional pages you are attaching to this document.

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Organ donation

Organ donation is donating organs, eyes, tissues or any other body part to other people in need.

I have initialed the option I prefer for this situation.

☐ **I do not** want to donate my organs, eyes, tissues or any other body parts. I do not allow this donation after I die.

☐ **I do** want to donate any or all of my organs, eyes, tissues or other body parts. I allow this donation after I die. My health care agent is authorized to start or continue supportive treatments or any interventions needed to maintain my organs, eyes, tissues or any other body part until donation has been completed.

☐ **I do** want to donate, but I want to **limit** my tissue and organ donations. I authorize the limited donation, as I've written below, after I die. My health care agent is authorized to start or continue supportive treatments or any interventions needed to maintain my organs, eyes, tissues or any other body part until donation has been completed.

_____

_____

☐ **I have not decided** whether to donate any or all of my organs, eyes, tissues or other body parts. I authorize my health care agent to make this decision after I die.

Autopsy

An autopsy is done to confirm cause of death or to advance medical science. There may be costs for an autopsy.

I have initialed the option I prefer for this situation.

☐ **I do not** want an autopsy done unless required by law.

☐ **I do** allow my health care agent to request an autopsy if it can help others understand the cause of my death or help my family members make decisions about their future health care.

☐ **I have not decided** whether I would allow an autopsy. I authorize my health care agent to make this decision after I die.

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Comments or instructions to health care providers (optional)

Note: Use this space to write any additional instructions or messages to your health care team which have not been covered in this health care directive, or to expand or clarify your wishes, goals and values. You may leave this space blank.

Other comments or instructions for my health care agent (optional)

Note: Use this space to write any additional instructions or messages to your health care agent which have not been covered in this health care directive. You may leave this space blank.

For example, you may write down the names of family, friends or others close to you that you **want** or **do not want** to be part of your medical discussions such as "I do not want _____ to be part of my medical discussions." Or, "I would like _____ and _____ to be part of my medical discussions."

Note: Please sign and date any additional pages you are attaching to this document.

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Part 3: My Hopes and Wishes

Note: This section is optional but helpful for your health care agent(s) and care circle members who are involved in helping to make health care decisions for you at the end of your life.

I want those involved in my health care and health care decisions to know my following thoughts and feelings:

1. The things that make life most worth living to me are (list things that get you up in the morning):

2. My beliefs about when life would no longer be worth living (list examples of situations in which living would be worse than dying):

3. My choices about specific medical treatments, if any (this could include your choices about ventilators, dialysis, antibiotics, tube feedings, hospice care or palliative care):

Hospice Care

Hospice care focuses on your comfort and quality of life when your health care provider believes you have 6 months or less to live.

Palliative Care

Palliative care is available if you are in any stage of advanced illness. It focuses on treating symptoms, emotional and spiritual concerns, and helps you and your family understand your illness and treatment choices.

Note: Please sign and date any additional pages you are attaching to this document.

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4. My hopes and wishes about how and where I would like to die:
(Start your sentence with "If possible, I would like…)

5. If I am nearing my death, I would appreciate the following for comfort and support:
(Think about comfort measures or items, and support from visitors.)

6. Share your thoughts and feelings about how the people caring for you can provide spiritual care that honors your religious, cultural or faith traditions.

7. My religious, spiritual or faith affiliation:

I am of the _____ faith, and am a member of the _____ faith

community in (city) _____. Please try to notify them of my death and arrange for them to provide my after-death arrangements or memorial service.

I prefer to be buried / cremated. (circle one)

Instructions for care of my body after death:

8. Other choices/instructions (such as instructions about donating your body to science):

Note: Please sign and date any additional pages you are attaching to this document.

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Part 4: Making My Health Directive Valid

Under Wisconsin law, you must sign and date this document in Wisconsin in front of two witnesses.

- Social workers and chaplains are the only health care providers who can witness in Wisconsin.
- In addition, your witnesses cannot:
  - be related to you or named as a health care agent in this document
  - have the right to collect money or property from your estate after you die that they know about
  - be directly financially responsible for your health care.

Important: Wait to sign your name until you are in front of two witnesses. The signature dates must match.

I have made this document willingly. I am thinking clearly. This document expresses my choices about my health care decisions:

Signature: _____ Date: _____

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

Signature: _____

Print name: _____ Date: _____

The reason I cannot sign my name is: _____

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Two witnesses

I declare that:

- This document was signed in my presence by the person completing this document or by an individual that the person completing this document authorized to sign on their behalf.
- I am at least 18 years of age.
- I am not named as a health care agent in this document.
- I am not related by blood, marriage, registered domestic partnership or adoption to the person signing this document.
- I am not directly financially responsible for this person's health care.
- I am not a health care provider directly serving the person at this time.
- I am not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- I am not aware that I have the right to inherit or collect any money or property from the person's estate after the person dies.

Signature of Witness 1:

Signature: _____ Date: _____

Print name: _____

Address: _____

Signature of Witness 2:

Signature: _____ Date: _____

Print name: _____

Address: _____

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Part 5: Next Steps

Now that you have completed your health care directive, you have a few more steps to finish. This page is not part of your health care directive. You may separate it from the rest of the document and use it as a worksheet.

Checklist

- ❑ Keep the original copy of your health care directive where it can be easily found.
- ❑ Give a copy of your health care directive to your health care agent, health care provider(s) (so it can be scanned into your medical record) and those who may be involved in your health care or in helping to make health care decisions for you.
- ❑ Talk to anyone who may be involved if you have a serious illness or injury. Make sure they know who your health care agent is and understand your wishes, goals and values.
- ❑ If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be scanned into your medical record.
- ❑ Review, update or complete a new health care directive at least every 5 years or if:
  - — there is a relationship change, such as divorce, estrangement or death
  - — you are diagnosed with a serious health condition
  - — your health gets significantly worse, especially if you are unable to care for yourself or are unable to live on your own
  - — your health care agent is no longer willing or able.
- ❑ If your choices change, fill out a new health care directive and give new copies to your health care agent, health care provider(s), others who may be involved in your health care or in helping to make health care decisions for you and anyone who has copies of your old health care directive. Tell them what changed and to destroy any old copies.

Who has copies of this document

Give a copy of this document to your health care agent; health care provider(s); religious, spiritual or faith leader; and those who may be involved in your health care or making health care decisions for you. Also take a copy of your health care directive with you when you go to the hospital or clinic for care.

1. _____

2. _____

3. _____

4. _____

5. _____

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