# *Power of Attorney for Health Care*

## Personal Information

| Name *(First, Middle, Last)* | | | Birth Date *(Month DD, YYYY)* |
|---|---|---|---|
| Phone *Home* | *Work* | *Mobile* | |
| Street Address | City | State | ZIP Code |

With this legal form, I am naming who I would want to make health care choices for me if I am not able. I expect to make my own choices as long as I am able, including stopping, starting, continuing or refusing medical care. If two doctors (or one doctor and one psychologist) say that I am not able to make my own decisions, I trust my health care agent(s) to honor my choices. I **know** this is for health care only, not financial or business decisions.

## Part A: My Health Care Agent(s)

If I am no longer able to make my own health care decisions, then I want one of the following people to make them for me.

*When choosing your health care agent, choose someone who knows you well, someone you trust, and someone who agrees to respect and honor your choices under stress. This person:*

- *Must be at least 18 years old*
- *Should not be your health care provider or work for your health care provider (unless he/she is a close relative)*

### First Choice

| Name *(First, Middle, Last)* | | | Relationship |
|---|---|---|---|
| Phone *Home* | *Work* | *Mobile* | |
| Street Address | City | State | ZIP Code |

### Second Choice

| Name *(First, Middle, Last)* | | | Relationship |
|---|---|---|---|
| Phone *Home* | *Work* | *Mobile* | |
| Street Address | City | State | ZIP Code |

### Third Choice

| Name *(First, Middle, Last)* | | | Relationship |
|---|---|---|---|
| Phone *Home* | *Work* | *Mobile* | |
| Street Address | City | State | ZIP Code |



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|---|---|
| | |

**I want my health care agent to be able to:** *(Draw a line through anything you do not want your health care agent to do.)*

- Make choices for me about my medical care like tests, medicine and surgery. If treatment already has been started, my health care agent can keep it going or stop it.
- Review and release my medical records as needed for my medical care.
- Arrange for my medical care and treatment in Wisconsin or any other state.
- Say which doctor or other health care provider may take care of me.

### Limits on Mental Health Treatment

Wisconsin law says that my health care agent may not admit or commit me to an institution or to a state treatment facility for mental diseases or intellectual disability. My health care agent may not consent to experimental mental health research or treatment, including electroconvulsive therapy or drastic mental health treatment procedures.

## Part B: Required Questions

*Check the box by your answer in each section. If you leave it blank, it will be taken as a "No."*

### 1. Nursing Home or Community-Based Residential Facility

| | |
|---|---|
| My health care agent may admit me somewhere for long term nursing care if needed. *(Note: Your agent is allowed to admit you somewhere for a short term stay anytime.)* | ☐ Yes ☐ No |

### 2. Feeding Tube

| | |
|---|---|
| My health care agent may decide to start, stop, continue or refuse a feeding tube for me. | ☐ Yes ☐ No |

### 3. Health Care Decisions during Pregnancy

| | |
|---|---|
| My health care agent may make decisions for me if I am pregnant. | ☐ Yes ☐ No ☐ Does not apply |

## Part C: Optional Questions

**I want to say more about what I believe and what I do and do not want.** *(If you need more space, add more pages.)*

### Donor Information

| | |
|---|---|
| ☐ | **Yes,** I would like to donate organs and tissue if it would help others.<br>Details:<br><br>*(If you have not already done so, you may sign papers and enroll online at www.donorregistry.wisconsin.gov.)* |
| ☐ | **No,** I do not wish to donate any part of my body. |

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| | |

## Part D: Making the Document Legal

*Two witnesses must watch you sign this and then they must sign below. *All three signature dates must match.*

**I agree with everything that is in this document. I am doing this willingly.**

| Patient Signature | *Date *(Month DD, YYYY)* |
|---|---|
| | |

### Statement of Witnesses

**By signing this as a witness, I agree that:**

- I am at least 18 years old.
- I am not related in any way to the person signing this form.
- I am not a health care agent of the person signing this form.
- I am not financially responsible for this person's health care.
- I am not a health care provider for this person.
- I do not work for this person's health care provider (except as a social worker or chaplain).
- I will not get money from this person's estate as far as I know.

**I know this to be the person in this document. I believe he or she is thinking clearly, knows what he or she is doing and is signing voluntarily. I watched him or her sign this document.**

**Witness #1**

| Signature | | | *Date *(Month DD, YYYY)* |
|---|---|---|---|
| Printed Name | | | Relationship |
| Street Address | City | State | ZIP Code |
| | | | |

**Witness #2**

| Signature | | | *Date *(Month DD, YYYY)* |
|---|---|---|---|
| Printed Name | | | Relationship |
| Street Address | City | State | ZIP Code |
| | | | |

## Part E: What to Do Next

- Be sure your health care agent(s) knows what you want and will honor your choices.
- Tell your family and close friends what you want and who your health care agent is.
- Review this at any of the "Five Ds":
  - **Decade:** Every 10 years.
  - **Death:** When someone close to you dies.
  - **Divorce:** If you are married to or living with your health care agent and you break up, this paper is no longer valid and you must make a new one.
  - **Diagnosis:** When you get a serious illness.
  - **Decline:** When your health declines.
- If you change your mind, tell your health care agent, family and close friends and change the paperwork.

# *Power of Attorney for Health Care* (continued)

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|---|---|
| | |

**Copies of this document have been given to:**

| ☐ Health Care Agent #1 | ☐ Health Care Agent #2 | ☐ Health Care Agent #3 |
|---|---|---|
| ☐ Doctor: | ☐ | |
| ☐ Hospital: | ☐ | |

**Reviewed by:**

| Name | Date *(Month DD, YYYY)* |
|---|---|
| Name | Date *(Month DD, YYYY)* |

## 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 interest 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.**