WISCONSIN
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states and the District of Columbia.

This package includes:
- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

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5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

6. Wisconsin does not maintain an Advance Directive Registry. However, you may record your advance directive with the registry of probate in the county of your residence

INTRODUCTION TO YOUR WISCONSIN ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **Wisconsin Advance Health Care Directive,** that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Your Wisconsin Advance Directive has four parts. Depending on your advance planning needs, you may complete Part II, Part III, or both depending on your advance planning needs. **You must complete Part IV.**

Part I contains a statutory notice that explains the significance of Part II, the **Wisconsin Power of Attorney for Health Care.** Part III, the **Wisconsin Declaration to Physicians**, is your state's living will. Part IV contains the signature and witnessing provisions so that your document will be effective.

Following your Advance Directive is a **Wisconsin Organ Donation Form**.

How do I make my Wisconsin advance health care directive legal?

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself in the presence of two adult witnesses (18 years or older)

Your two adult witnesses **cannot** be

- related to you;
- entitled to, or have a claim against, any portion of your estate;
- be directly responsible for your healthcare;
- your healthcare provider;
- an employee of your healthcare provider, other than a chaplain or social worker;
- an employee of an inpatient healthcare facility in which you are a patient, other than a chaplain or a social worker; or,
- your healthcare agent.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare

decisions for you.

Unless he or she is related to you, your agent **cannot** be:

- your treating healthcare provider,
- an employee of your treating healthcare provider,
- an employee of a healthcare facility in which you reside or are a patient, or
- a spouse of any of the above.

You can appoint a second person as your alternate agent. An alternate agent will step in if the person you name as agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your Wisconsin Power of Attorney for Health Care goes into effect when your doctor and one other doctor determines that you are unable to receive and evaluate information effectively or to communicate decisions to such an extent that you lack the ability to manage your healthcare decisions.

Your Declaration will go into effect when your doctor and one other doctor certify in writing that you are no longer able to make or communicate your healthcare decisions, and you have a terminal condition or are in a persistent vegetative state.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your healthcare agent does not have the authority to consent to:

- admitting or committing you on an inpatient basis to an institution for mental diseases,
- admitting or committing you to an intermediate care facility for the mentally retarded, a state treatment facility, or a treatment facility,
- experimental mental health research or psychosurgery, or
- electroconvulsive treatment of other 'drastic' mental health treatment procedures.

Your agent will be bound by the current laws of Wisconsin as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Wisconsin Advance Directive at any time by:

- defacing, burning, treating, or otherwise destroying the document itself;
- signing and dating a written statement of your intent to revoke your Wisconsin Power of Attorney for Health Care;
- expressing your intent to revoke your Wisconsin Advance Directive verbally in the presence of two witnesses (this revocation becomes effective only when your doctor is notified of the revocations); or
- executing another Wisconsin Advance Directive.

Unless you specify otherwise, if you designate your spouse or registered domestic partner as your agent, that designation will automatically be revoked by divorce or annulment of your marriage or the termination of the domestic partnership.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

If you are pregnant, you must initial the paragraph on page 6 of the form for Part II (Power of Attorney for Health Care) to be effective during your pregnancy. Part III (Declaration to Physicians) is not effective during your pregnancy.
Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

PART I

PART I. 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.

NOTICE

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 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 AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

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NOTICE (CONTINUED)

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.

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PART II

PART II. WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE

PRINT THE DATE

Document made this ________ day of ________________, _________.
(date) (month) (year)

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME, ADDRESS AND DATE OF BIRTH

I, ____
(print name)

____
(address)

____
(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 THE NAME, ADDRESS, AND PHONE NUMBER OF YOUR AGENT

____
(print name)

____
(address and telephone number)

to be my health care agent for the purpose of making health care decisions on my behalf.

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PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR ALTERNATE AGENT

If he or she is ever unable or unwilling to do so, I hereby designate

____
(print name)

____
(address)

____
(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.

AUTHORITY OF AGENT

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.

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MENTAL HEALTH LIMITATIONS

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 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.

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 initialed "Yes" in 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 TO INDICATE YOUR HEALTH CARE AGENT'S ADMISSION POWERS

1. A nursing home: Yes ____ No ____
2. A community-based residential facility: Yes ____ 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.

PROVISION OF A FEEDING TUBE

IF YOU WANT TO GIVE YOUR AGENT THE POWER TO REFUSE TUBE FEEDING ON YOUR BEHALF, INITIAL "YES"

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.
Withhold or withdraw a feeding tube: Yes ____ 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.

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IF YOU WANT YOUR AGENT TO MAKE MEDICAL DECISIONS FOR YOU IF YOU BECOME INCAPACITATED DURING PREGNANCY, INITIAL "YES"

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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HEALTH CARE DECISIONS FOR PREGNANT WOMEN

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.

Health care decision if I am pregnant: Yes ____ 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.

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 specific desires, provisions or limitations that I wish to state (add more items if needed):

____

____

____

____

____

____

____

(attach additional pages if needed)

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.

PART III

PART III. DECLARATION TO HEALTH PROFESSIONALS

PRINT YOUR NAME

I, ____(print name), 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, physician assistant, or advanced practice registered nurse honor this document as the final expression of my legal right to refuse medical or surgical treatment.

Automatic revocation under Wis. Stat. § 155.40(2) of the Power of Attorney for Health Care in Part II due to the principal's divorce, annulment of marriage, or termination of domestic partnership with his or her health care agent shall have no effect on this Declaration, Part III, which shall survive the invalidation of Part II.

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES REGARDING FEEDING TUBES IN THE EVENT YOU HAVE A TERMINAL CONDITION

1. If I have a **TERMINAL CONDITION**, as determined by a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, 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:

_____ YES, I 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**.)

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES REGARDING LIFESUSTAINING PROCEDURES IN THE EVENT YOU ARE IN A PERSISTENT VEGETATIVE STATE

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, the following are my directions regarding the use of life-sustaining procedures:

_____ YES, I 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**.)

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INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES REGARDING TUBE FEEDING IN THE EVENT YOU ARE IN A PERSISTENT VEGETATIVE STATE

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, the following are my directions regarding the use of feeding tubes:

______ YES, I want feeding tubes used if I am in a persistent vegetative state.
______NO, I do not want feeding tubes if I am in a persistent vegetative state.
(**If you have not initialed either box, feeding tubes will be used**.)

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

DIRECTIVES TO ATTENDING PROFESSIONAL

1. This document authorizes the withholding or withdrawing of life-sustaining procedures or of feeding tubes when a physician and another physician, physician assistant, or advanced practice registered nurse, one of whom is the attending health care professional, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.
2. The choices in this document were made by a competent adult. Under the law the patient's stated desires must be followed unless you believe the withholding or withdrawing of life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life- sustaining procedures or feeding tubes be used, this directive must be followed.
3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician, physician assistant, or advanced practice registered nurse who will comply. Refusal or failure to do so constitutes unprofessional conduct.
4. If you know that the patient is pregnant, this document shall have no effect during her pregnancy.

ADD PEOPLE WHO YOU PLAN TO GIVE COPIES OF YOUR DOCUMENT

LOCATION OF COPIES

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

________________________________ ________________________________

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PART IV

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR NAME

THE PRINCIPAL AND THE WITNESSES ALL MUST SIGN THE DOCUMENT AT THE SAME TIME

WITNESSES MUST SIGN AND PRINT THEIR NAMES, DATE, AND ADDRESSES HERE

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PART IV. EXECUTION

Signature ____________________________________ Date ________________

Printed Name ____

(The signing of this document by the principal revokes all previous powers of attorney for health care and declaration to health professions 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 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 No. 1:

Signature ____

(print) Name ___________________________________ Date _________

Address ____

Witness No. 2:

Signature ____

(print) Name ____________________________________ Date_________

Address ____

ANATOMICAL GIFTS (OPTIONAL)

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.)

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

Failing to initial any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

SIGN AND PRINT YOUR NAME AND THE DATE

_____________________________________ __________________
(signature of principal) (date)

____
(printed name of principal)

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