WISCONSIN LIVING WILL

Declaration to Physicians

PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT BEFORE YOU COMPLETE AND SIGN IT

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.

1. If I have a TERMINAL CONDITION, as determine by two 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:

   _____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 checked either line, feeding tubes will be used.

2. If I am in a PERSISTENT VEGETATIVE STATE, as determined by two physicians who have personally examined me, 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 checked either line, life-sustaining procedures will be used.

3. If I am in a PERSISTENT VEGETATIVE STATE, as determined by two physicians who have personally examined me, 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 used if I am in a persistent vegetative state.

   If you have not checked either line, 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.

ATTENTION: You and the two witnesses must sign this document at the same time.

Signed _____ Date _____

Address _____

Date of Birth _____

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness Signature _____ Date _____

Print Name _____

Witness Signature _____ Date _____

Print Name _____

DIRECTIVES TO ATTENDING PHYSICIAN

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when two physicians, one of whom is the attending physician, 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 that withholding or withdrawing 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 states 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 who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

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

_____

_____

WISCONSIN 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 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.

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 DOCUMENT 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 PROVISIONS.

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.

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 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 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 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 A 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 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 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 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 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:
(print) Name _____
Date _____
Address _____
_____
Signature _____
Witness No. 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 _____