How to Complete This
Power of Attorney for Health Care

Overview

The attached power of Attorney for health care form is a legal document, developed to meet the legal requirements for Wisconsin, Minnesota, and Iowa. This document provides a way for a person to create a power of attorney for health care that will meet the basic requirements for these states.

This power of attorney for health care form allows you to appoint another person or persons to make your health care decisions if you become unable to make these decisions for yourself. The person (or persons) you appoint is your health care agent. This document gives your health care agent authority to make your decisions only when you have determined incapable by your physician(s) to make your health care decisions. It does not give your health care agent any authority to make your financial or other business decisions.

Before completing this power of attorney for health care form, take time to read it carefully. It is also very important that you discuss your views, values, and this document with your health care agent! If you do not closely involve your health care agent and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future health care, but do not want to or cannot use this power of attorney for health care form, ask your health organization or attorney for advice about alternatives.

How to complete this Document

This power of attorney for health care form is divided into four parts.

Part I - Appointing a Health Care Agent.
Part II - Authority of the Health Care Agent.
Part III - Statements of Desires, Special Provisions, or Limitations.
Part IV - Making the Document Legal.

Steps to Follow:

In each of these four parts of the attached document you will find instructions. Read and follow these instructions carefully. The basic things you must do are:

1) provide the information on page 1;
2) appoint at least one health care agent on page 3;
3) indicate choices for sections 1, 2, and 4 on pages 4 and 5;
4) indicate any written instructions you want in part III;
5) sign and date the document on page 8; and
6) have the document witnessed.

If you wish to donate your body after death to medical science, you should contact the closest medical school to your state and make arrangements through that medical school. Here are some places to contact.

University of Wisconsin-Madison School	(608)262-2888
Mayo Medical School	(507)284-2693
University of Iowa Medical School	(319)335-7762

After Completing This Document

After you complete the document, make copies to be given out as follows:

- one copy for yourself;
- one copy for each health care agent appointed in the document;
- one copy to share and discuss with your physician;
- one copy for your record at the hospital where you would go in an emergency;
- extra copies to share with others if you wish (loved ones, your minister/clergy/rabbi, and your attorney).

A photo or fax copy is as legally valid as an original.

Need Assistance?

If you need assistance in completing this document you may contact the following places:

Gundersen Lutheran

Gundersen Lutheran Medical Center

- Pastoral Care
  (608)782-7300, Ext. 3620
  (800)362-9567, Ext. 3620
- Patient Service Representative
  (608)782-7300, Ext. 6000
  (800)362-9567, Ext. 6000
- Care Connection
  (608)791-4717
  (800)362-9567, Ext. 4717

Gundersen Lutheran – Onalaska Clinic

- Social Services
  (608)796-8159
  (800)362-9567, Ext. 8159

Or call the Gundersen Lutheran Regional Clinic or affiliate in your community.

Franciscan Skemp Healthcare

Mayo Health System
La Crosse Medical Center
Patient and Family Services
(608)791-9754
(800)362-5454, Ext. 9754

La Crosse Eldercare
(608)791-9505
(800)362-5454, Ext. 9505

La Crosse Home Health Services
(608)791-9790
(800)362-5454, Ext. 9790

Or call the Franciscan Skemp Healthcare affiliates in your community. All Franciscan Skemp Healthcare service sites can be accessed through our toll-free number: (800)362-5454.

Power of Attorney for Health Care

For

Name: ____

Date of Birth: _______________________________________

Address: ____

Telephone: ____

Copies of this document have been given to:

1. ____
2. ____
3. ____
4. ____
5. ____

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 a person who you would want to make health care decisions for you if you become 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 you might specify. 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 heath care decisions, 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 power 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 provider(s) 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 designation of your spouse as health care agent shall no longer be valid.

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 document of gift you make have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gift 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.

Part I – Appointing a person to make my health care decisions when I can't make my own health care decisions.

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my Health Care Agent. This person will make my health care decisions when I am determined to be incapable to make health care decisions as provided under state law.

Instructions for Completing this part:

When selecting someone to be your health care agent, pick someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Make sure that you pick someone who will closely follow what you want and will be a good advocate for you. What ever you do, take time to discuss this document and your views with the person(s) you pick to be your agent.

Your Health Care Agent should be at least 18 years or older and should not be your health care providers or an employee of your health care provider unless they are a close relative. Space has been provided for a second and third alternate health care agent.

The person I choose as my Health Care Agent is:

Name: ____

Day phone: ____________________ Evening phone: ____________________

Address: ____

City: ____________________ State: ______________ Zip: __________

If this health care agent is unable or unwilling to make these choices for me, or if my spouse is designated as my Health Care Agent and our marriage is annulled or we are divorces or legally separated, **then my next choice for health care agent is:**

Second Choice

Name: ____

Day phone: ____________________ Evening phone: ____________________

Address: ____

City: ____________________ State: ______________ Zip: __________

If this health care agent is unable or unwilling to make these choices for me, or if my spouse is designated as my Health Care Agent and our marriage is annulled or we are divorced or legally separated, **Then my next choice for a health care agent is:**

Third choice

Name: ____

Day phone: ________________________ Evening phone: ____________________

Address: ____

City: ___________________________ State: _______________ Zip: ___________

Part II – General Authority of the Health Care Agent

I want my Health Care Agent to be able to do the following (Please cross out anything you do not want your Health Care Agent to do that is listed below):

- To make choices for me about my medical care or services, like test, medicine, and surgery, if treatment has already been started, my Health Care Agent can keep it going or have it stopped depending upon my stated instructions or my best interests.
- To interpret any instruction I have given in this form or given in other discussions according to my Health Care Agent's understanding of my best interests.
- To review and release my medical records and personal files as needed for my medical care.
- To move me to another state if needed.
- To determine which health professionals and organizations provide my medical treatment.

Instructions for Completing these Sections:

Initial either a "yes", "no", or "not applicable" box in the following three sections. Draw a line through the box and statement you do not want. If you do not initial any box in a section and make no clear choice, that statute in Wisconsin says your choice is considered to be "no". This means if you do not indicate a choice, in Wisconsin only a court may make such a decision and not your health care agent.

1. **Agent authority to admit me to a nursing home or community-based residential facility for purpose of long-term care.**

_____ 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, subject to any limits I have set fourth in this document.

_____ No, my Health Care Agent does not have authority to admit me to a Wisconsin nursing home or a community-based residential facility for a long term stay. *If I check "no", I cannot be withheld or withdrawn in Wisconsin without a court order.*

2. **Agent authority to order the withholding or withdrawal of feeding tube and IV hydration.**

_____ Yes, my Health Care Agent has authority to have a feeding tube or IV hydration withheld or withdrawn from me subject to any limits I have set forth in this document.

_____ No, my Health Care Agent does not have authority to have a feeding tube or IV hydration cannot be withheld or withdrawn from me, *If I check "no" feeding tubes or IV hydration cannot be withheld or withdrawn in Wisconsin without a court order.*

3. Agent authority to make decisions if I am pregnant.

_____ Yes, my Health Care Agent has authority to make decisions for me if I am pregnant, subject to any limits I have later set forth in this document.

_____ No, my Health Care Agent does not have authority to make decisions for me if I am pregnant. If I check "no", health care decisions can not be made for me without a court order during my pregnancy.

_____ Not Applicable

Part III – Statement of Desires, Special Provisions, or Limitations

My Health Care Agent shall make decisions consistent with my stated desires, and is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my Health Care Agent and/or physician providing my medical care. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, or my Health Care Agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own health care.

Instructions for Completing this Part:

You are **not required** to provide any written instructions or make any selections in Part III. If you choose **not** to provide any instructions, your health care agent will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, draw a line and write "no instructions" across the page.

Stopping Attempts of Life Prolonging Treatments:

(Either initial the line or draw a line through the statement.)

_____ If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with myself, my family, friends, and environment, I want to stop or withhold **all** treatments that might be used to prolong my existence. Treatments I would not want if I were to reach this point include tube feedings, IV hydration, respirator/ventilator, CPR, and antibiotics.

Pain and Symptom Control:

(Either initial the line or draw a line through the statement.)

_____ If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable, even if it risks my dying sooner.

Cardiopulmonary Resuscitation (CPR):

My CPR choice listed below may be reconsidered by my Health Care Agent in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency. Other documents may be needed to control the actions of emergency personnel.

(initial the line or draw a line through the statement.)

_____ I want Cardiopulmonary Resuscitation (CPR) attempted if my heart stops.

_____ I do not want CPR attempted if my heart stops.

_____ I want Cardiopulmonary Resuscitation (CPR) attempted unless my physician determines one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long term survival if my heart stops and the process of resuscitation would cause significant suffering.

Upon My Death:

After my death the following are my instructions. If my Health Care Agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

Donation of My Organs or Tissue:

(Initial one and draw a line through the statements that you do not want.)

_____ I wish to donate only the following organs or parts if possible (name the specific organ or tissue): ____.

_____ I wish to donate any organs or tissue if I am a candidate.

_____ I do not want to donate any organ or tissue.

Autopsy:

(Initial both the first and second choice or just one choice and draw a line through the statements that you do not want.)

_____ I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them in their future health care decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

_____ I do not want an autopsy performed on me.

Religion:

I am of the ____________________ faith, and am a member of the ________________________ ____________________ congregation, synagogue, or worship group. Phone number of congregation, synagogue, or worship group (if known): ________________________________.

Persons I want My Agent to Include in the Decision Process:

I ask my Health Care Agent include the following persons in my health care decisions if there is time: ____ ____.

Other Instructions or Limitations I want My Health Care Agent to Follow:

If I am Nearing My Death, I want the Following: (List things that would make dying more meaningful to you.)

If I am Nearing My Death and Cannot Speak, I Want My Friends and Family To Know:

Part IV – Making the Document Legal

Instructions for Completing this Part:

Wisconsin residents must have this document signed and dated in the presence of two witnesses. Minnesota or Iowa residents may have this document signed and dated in the presence of two witnesses or a notary public. If this document is notarized, some health providers in Wisconsin may not consider it to be legally valid in Wisconsin. To assure that it is legally valid in all three states, it is advisable to have this document witnessed as suggested,

I am thinking clearly, I agree with everything that is written in this document and I have made this document willingly.

____________________________________ ____________________________
My signature Date

If I cannot sign my name, I can ask someone to sign this document for me.

____
Signature of person who I ask to sign this document for me.

____
Print the name of the person who I asked to sign this document for me.

Statement of Witnesses

I personally know the person who signed this document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and believe that he or she did so voluntarily.

By signing this document as a witness, I certify that I am:

- at least 18 years of age.
- not a health care agent appointed by the person signing this document.
- not related to the person signing this document by blood, marriage, or adoption.
- not directly financially responsible for that person's health care.
- not a health care provider directly serving the person at this time.
- not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- not aware that I am entitled to or have a claim against the person's estate.

Witness number 1:

____________________________________ ____________________________
My signature Date

____
Print name

____
Address

Witness number 2:

____________________________________ ____________________________
My signature Date

____
Print name

____
Address

Instructions for Notarization:

Residents of Iowa and Minnesota may have this document signed by a notary public authorized in their state instead of having two witnesses.

Notary Public

In my presence on _________________________ (date), _____________________ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a Health Care Agent or alternate Health Care Agent in this document.

(Notary Stamp)

____
Signature of Notary