

WISCONSIN

PATIENT EDUCATION

# Health Care Directive

*Making Your Health Care Choices Known*



Allina Health

# My Health Care Directive

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

I understand that it is my responsibility to talk about my wishes, goals and values with my health care agent and family, friends or others close to me. 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**Any health care directive document created before this is no longer valid.**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

# 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, 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 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 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 physician.

NAME, DOB, MRN

patient sticker

# 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 his or her ability to willingly make decisions based on my choices. I trust this person to follow my wishes, goals and values under times of 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) \_\_\_\_\_

NAME, DOB, MRN

## 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) \_\_\_\_\_

NAME, DOB, MRN

## 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:

- 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 his or her 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 he or she 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.

NAME, DOB, MRN

patient sticker

## 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, in his or her 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.**

NAME, DOB, MRN

patient sticker

### 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. I am either a male or no longer 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 he or she may take, I have written them below.

---

---

---

---

NAME, DOB, MRN

## 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 can't make them
- 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
- 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.

NAME, DOB, MRN

patient sticker

## 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 and comfort medicines 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 family has arrived.

---

---

---

---

---

---

---

---

NAME, DOB, MRN

## 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 and comfort medicines 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 on dialysis. You may leave this space blank.

---

---

---

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

NAME, DOB, MRN

## 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.

**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.

NAME, DOB, MRN

patient sticker

## 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.

## Part 3: My Hopes and Wishes

**Note:** This section is optional but helpful for your health care agent and family, friends or others 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.

NAME, DOB, MRN

4. My hopes and wishes about how and where I would like to die:

5. If I am nearing my death, I would appreciate the following for comfort and support:

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

7. My religious 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 funeral/memorial.

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

I would like to include the following people, music, rituals, etc., if possible:

8. Other choices/instructions (this could include instructions about donating your body to science):

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

## 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: \_\_\_\_\_

## 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 his or her 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: \_\_\_\_\_

NAME, DOB, MRN

## 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 major family change, such as divorce 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), clergy, 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. \_\_\_\_\_

## **Allina Health advance care planning**

- Allina Health has a secure, online health care directive that you can complete.  
Go to [allinahealth.org/acp](http://allinahealth.org/acp) and sign up for a My Account with Allina Health.
- You can also attend a free class on how to fill out a health care directive.  
Check out the class listings at [allinahealth.org/acp](http://allinahealth.org/acp) or call 612-262-2224 to get scheduled.



Allina Health

[allinahealth.org](http://allinahealth.org)