ORTHOPAEDIC HOSPITAL
OF WISCONSIN

Name: _____

Date of birth: _____

Address: _____

Telephone: _____

This document is on file at: _____

Copies of this document have been given to:

1. _____

2. _____

3. _____

4. _____

5. _____

Please consider the following:

- Give your health care agent (see below) a copy of this document
- Give a copy of this document to your health care provide
- Talk to your health care provider about your health care preferences
- If you go to a hospital or nursing home, provide the facility with a copy of this document
- Let family and close friends know about this document

Courtesy of: Orthopaedic Hospital of Wisconsin

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 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, health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner, and your marriage is annulled or you are divorced or your 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 or other primary care provider.

This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.

POWER OF ATTORNEY FOR HEALTH CARE

I, name: _____

Address: _____

Date of birth: _____, of sound mind intend to make a Power of Attorney for Health Care. I am doing so voluntarily.

This document names the person(s) I choose to make decisions for me when I am no longer able to make my own health care decisions. This person will be my Health Care Agent. I understand this document will not take effect until a statement of incapacity* (in other words, I cannot make decisions for myself) has been completed.

I understand "health care decision" means an informed decision to accept, continue, discontinue or decline a treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

I understand that it is important for my Health Care Agent and me to have ongoing discussions about my health and health care choices.

If I require treatment in a state that does not recognize this Power of Attorney for Health Care, I want my Health Care Agent to be recognized as my chosen decision maker and the instructions within this document to be followed.

My Health Care Agent is at least 18 years old and is not one of my health care providers or an employee (or the spouse of an employee) of my health care provider or facility unless they are a close relative.

NAMING HEALTH CARE AGENT(s)

If I am no longer able to make health care decisions for myself, I choose:

Name: _____

Address: _____

and telephone number(s): _____ _____ _____ 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 choose:

Name: _____

Address: _____

and telephone number(s): _____ _____ _____ to be my Health Care Agent for the purpose of making health care decisions on my behalf.

*For purposes of this document, "incapacity" means 2 physicians or a physician and a psychologist, nurse practitioner or physician assistant have personally examined me and signed a statement that, in their opinion, I lack the ability to manage my health care decisions. That is, I am unable to understand or tell others about my health care decisions.

If applicable, a copy of the Statement of Incapacity must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

In the event I lack the ability to make my health care wishes known, my Health Care Agent has the authority to make health care decisions for me.

I have talked with my Health Care Agent(s) about my wishes and believe they understand my wishes. My Health Care Agent should try to communicate with me about possible health care treatment, intervention or care in an alternate care facility. This may mean the use of a communication board, writing or blinking my eyes.

If I have not given direction about the health care treatment in question, my Health Care Agent shall base decision(s) on their understanding of my wishes and values, and on what my Health Care Agent believes to be in my best interest.

Unless I have stated otherwise, I want my Health Care Agent to be able to do the following:

- make decisions for me about my medical care, including tests, medicine and surgery
- explain any direction I have given in this form or other discussions to my care team
- move me to another state if needed
- decide which health care providers and systems can provide my medical care
- request, review and receive any information, oral or written, about my physical or mental health, including medical and hospital records
- complete documents that may be required in order to obtain information about my physical and mental health
- allow for information to be reviewed and discussed

If none of the Health Care Agent(s) named are available after reasonable tries to contact them, I ask my family members, loved ones or those close to me not named in the document to talk with my health care providers and or any later-appointed guardian about the statements and preferences in this document.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My Health Care Agent may not admit or commit me to a facility for mental diseases or a facility for persons with cognitive disability. My Health Care Agent may not consent to have me participate in experimental mental health research or brain surgery, electric shock treatment or drastic mental health treatment procedures.

SPECIFIC STATEMENTS OF AUTHORITY GRANTED

My Health Care Agent has the general authority to make decisions for me after this Power of Attorney for Health Care has been activated. My Health Care Agent's authority about admission to nursing homes or community-based residential (living) facilities, use of a feeding tube and health care decisions during pregnancy are stated below.

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 recovery, therapy or respite care.

☐ Yes, I give my Health Care Agent the authority to admit me to a nursing home or community-based residential facility for a long-term stay subject to any limits I have set forth in this document.

☐ No, I do not give my Health Care Agent the authority to admit me to a nursing home or a community-based residential facility for a long-term stay.

If I have not checked either "Yes" or "No" above, my Health Care Agent may admit me for short-term stays of less than 90 days to recover or regain my health or less than 28 days for respite. If I need long term care it may be necessary for my family or loved ones to ask the court for guardianship in order to obtain the authority to make placement decisions on my behalf.

USE OF A FEEDING TUBE
(Medically Assisted Nutrition and Water)

My Health Care Agent may be asked to consider starting a feeding tube or removing a feeding tube.

☐ Yes, I grant my Health Care Agent the authority to have a feeding tube withheld or withdrawn from me, unless my health care team has advised that, in their professional judgment, this will cause me pain or will reduce my comfort.

☐ No, I do not grant my Health Care Agent the authority to have a feeding tube withheld or withdrawn from me. I am aware that if I check "no", court involvement may be required for decisions to withhold or withdraw a feeding tube.

My Health Care Agent may not have oral nutrition or hydration withheld or withdrawn from me unless the provision of the nutrition or hydration is not medically indicated.

If I have not checked either "Yes" or "No" above, I understand my Health Care Agent may not have a feeding tube withdrawn from me.

HEALTH CARE DECISIONS DURING PREGNANCY

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

☐ No, I do not grant my Health Care Agent the authority to make decisions for me if I am pregnant. I am aware that if I check "no", court involvement may be required for health care decision making during my pregnancy.

☐ This decision making authority is not applicable to me.

If I have not checked either "Yes" or "No"above, my Health Care Agent may not make health care decisions for me during pregnancy.

I want my Health Care Agent(s) and providers to know:

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: _____

(signing of this document revokes all previous Power of Attorney for Health Care documents)

STATEMENT OF WITNESSES

The person making this document personally came before me. I believe him/her to be of sound mind and at least 18 years of age. I personally witnessed him/her sign this document, and I believe that he/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 making this document
- not related to the person making this document by blood, marriage, adoption or domestic partnership
- not directly financially responsible for the 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
- not aware that I have a claim against the person's estate

Witness Number 1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness Number 2

Print name: _____ Date: _____

Address: _____

Signature: _____

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

(optional but recommended if agents are present at the time of completing this document)

I understand: _____ has selected me to be their Health Care Agent or alternate Health Care Agent if they are found to be unable to make health care decisions themselves.

Agent signature: _____

Address: _____

Alternate agent signature: _____

Address: _____

Optional Section
STATEMENT OF PREFERENCES

The following are my preferences. I ask my Health Care Agent and medical providers to act in a manner consistent with my preferences.

Life Prolonging Treatments: (such as a breathing or kidney machine or receiving nutrition other than by mouth).

If I experience prolonged suffering and illness that will lead to death or that is most likely not curable my preference about life prolonging treatments is:

I understand I will continue to receive care, including pain and comfort medicines, as well as food and fluids by mouth if I am able to swallow safely.

Code Status: Whether or not to use Cardiopulmonary Resuscitation (CPR).
CPR means pushing on chest, shocks and using a mask or tube to breathe for you.
*Do Not Resuscitate **(DNR)** means no use of CPR, shocks, using a mask or tube or other extreme actions to get your heart started or get you breathing again. DNR means continuing usual care including care of pain or discomfort .*

I understand decisions about Code Status can be difficult and dependent on my medical condition.

My preference about CPR or DNR is:

If I have an appropriate medical condition for which I prefer DNR, I understand it is important to complete a Community DNR order and wear a DNR bracelet to communicate my Code Status to Emergency personnel.

Implantable Cardiac Devices (if applicable)

I currently live with either an Implantable Cardioverter-Defibrillator (ICD) or a Pacemaker device. I understand decisions about the continued use of the devices can be difficult and dependent on my medical condition.

If my medical condition worsens, my preference is:

ORGAN DONATION

Upon my death (check one):

☐ I wish to donate only the following organs or parts: _____.

☐ I wish to donate any needed organ or part.

☐ I wish to donate my body for medical research if needed.

☐ I refuse to make an organ donation.

Not selecting a box above is no indication of my desire to make or refuse to donate my organs.

DONATION OF MY ORGANS OR TISSUE FOR MEDICAL RESEARCH

Donation of your body for medical research after death requires arrangements be made in advance. In accordance with my selection above, I authorize donation of my organs and tissue for transplantation and the remainder of my body, organs and tissue for medical research.

☐ I authorize donation of my entire body, organs and tissue for medical research.

☐ I do not authorize donation of any part of my body, organs or tissue for medical research.

AUTOPSY

By law the medical examiner may require an autopsy as deemed necessary. If an autopsy is not required by a medical examiner, my preference is:

☐ I do not object to an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future health care decisions.

☐ I do not object to an autopsy if it can help advance medicine or medical education.

Signature: _____ Date: _____