The La Crosse Region
Power of Attorney for Healthcare Document
and Instructions for Completing this Document

Overview

The attached power of attorney for healthcare 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 healthcare that will meet the basic requirements for these states.

This power of attorney for healthcare form allows you to appoint another person and alternate persons to make your own healthcare decisions if you become unable to make these decisions for yourself. The person you appoint is called your **healthcare agent**. This document gives your healthcare agent authority to make your decisions only when you have been determined incapable by your physician(s) to make your healthcare decisions. It does not give your healthcare agent any authority to make your financial or other business decisions. In addition, it does not give your healthcare agent authority to make certain decisions about your mental health treatment.

Before completing this power of attorney for healthcare form, take time to read it carefully. **It is also very important that you discuss your views, values, and this document with your healthcare agent**. If you do not closely involve your healthcare 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 healthcare, but do not want to or cannot use this power of attorney for healthcare form, ask your health organization or attorney for advice about alternatives.

How to Complete This Document

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

Part I - Appointing a Healthcare Agent
Part II - Authority of the Healthcare Agent
Part III - Statement of Desires, Special Provisions, or Limitations
Part IV - Making the Document Legal

Steps to Follow:

In each of the 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 information on page 1
2) appoint at least one healthcare agent on page 3
3) indicate choices for sections 1, 2, and 3 on page 5
4) indicate any written instructions you want in Part III
5) sign and date the document on page 10
6) have the document witnessed. Both witnesses must be present when you sign this document.

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

University of Wisconsin-Madison Medical School	608-262-2888
Mayo Medical School	507-284-2693 or 507-284-9170
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 healthcare 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 clergy, and your attorney)

A photo or fax 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. 51347
  800-362-9567, ext. 51347
- Advance Care Planning Coordinator
  608-782-7300, ext. 56000
  800-362-9567, ext. 56000

Gundersen Lutheran Onalaska Clinic

- Social Services
  608-775-8159
  800-362-9567, ext. 58159

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

Mayo Clinic Health System

Franciscan Healthcare - La Crosse

- Advance Directives Coordinator
  608-392-9754
  800-362-5454, ext. 22221

- Elder Services
  608-392-9505
  800-362-5454, ext. 29505

- Home Health Services/Hospice
  608-392-9790
  800-362-5454, ext. 29790

Or call the Mayo Clinic Health System affiliate in your community. All Mayo Clinic Health System sites can be accessed through a toll-free number: 800-362-5454.

Power of Attorney for Healthcare

for

Name:_____

Date of Birth:_____

Address:_____

Telephone: _____

Copies of this document are being or have been given to following health organizations and people (provide copies to your hospital, physician, and healthcare agents; and copies might also be given to close family, friends and clergy.):

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

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Power of Attorney for Healthcare Document

Notice to the Person Making this Document

You have the right to make decisions about healthcare. No healthcare may be given to you over your objection, and necessary healthcare may not be stopped or withheld if you object.

Because your healthcare 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 healthcare.

In order to avoid this problem, you may sign this legal document to specify a person who you would want to make healthcare decisions for you if you become unable to make those decisions personally. That person is known as your healthcare 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 healthcare that you do or do not desire, and you may limit the authority of your healthcare agent. If your healthcare agent is unaware of your desires with respect to a particular healthcare decision, 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 powers to make healthcare decisions for you. It revokes any prior power of attorney for healthcare that you may have made. If you wish to change your Power of Attorney for Healthcare, 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 healthcare 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 designation of your spouse as healthcare 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 may have made. You may revoke or change any anatomical gift that you make in 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 healthcare decisions when I can not make my own healthcare decisions

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

Instructions for Completing this Part:

When selecting someone to be your healthcare 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. Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your agent(s).

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

The person I choose as my Healthcare Agent is:

Name:_____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address:_____

City: _____ State: _____Zip: _____

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If this healthcare agent is unable or unwilling to make these choices for me; or if my spouse is designated as my Healthcare Agent and our marriage is annulled or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

Second Choice (1st alternate agent)

Name:_____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address:_____

City: _____ State: _____Zip: _____

If this healthcare agent is unable or unwilling to make these choices for me, or my spouse is designated as my Healthcare Agent and our marriage is annulled or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

Third choice (2nd alternate agent)

Name:_____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address:_____

City: _____ State: _____Zip: _____

Part II - General Authority of the Healthcare Agent

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

- To make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, my healthcare agent can keep it going or have it stopped depending upon my stated instructions or my best interests.
- To interpret any instructions I have given in this form or given in other discussions according to my healthcare agent's understanding of my wishes and values.
- To review and release my medical records and personal files as needed for my medical care.
- To arrange for my medical care and treatment in Wisconsin, Minnesota and Iowa or any other state, as my healthcare agent thinks appropriate.
- To determine which health professionals and organizations provide my medical treatment.
- To make decisions about organ/tissue or body donation decisions (anatomical gifts) after my death according to my known wishes or values.

Instructions for Completing these Sections:

Put your initials on the line (e.g. JD) to indicate you have selected a "yes", "no", or "not applicable" in the next three sections. Draw a line through the box and statement you do not select (e.g. ~~No, my healthcare…~~). If you do not initial any box in a section and make no clear choice, the 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 healthcare agent.

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

   _____ **Yes**, my healthcare 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 forth in this document.

   _____ **No**, my healthcare 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 initial "no" or leave this section blank, I cannot be admitted to a Wisconsin long-term care facility without a court order.*

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

   _____ **Yes**, my healthcare 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 healthcare agent does not have authority to have a feeding tube or IV hydration withheld or withdrawn from me. *If I initial "no" or leave this section blank, 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 healthcare 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 healthcare agent does not have authority to make decisions for me if I am pregnant. *If I check "no" or leave this section blank, healthcare decisions can not be made for me during my pregnancy without a court order.*

   _____ **Not Applicable**, because I am either a male or no longer capable of becoming pregnant.

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

My healthcare 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 healthcare agent and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this Power of Attorney for Healthcare, or my healthcare agent cannot be contacted, I want the instructions below to be followed based on my common law constitutional right to direct my own healthcare.

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 healthcare 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 put your initial (e.g. JD) on the line next to each statement if you agree, or draw a line through the statement if you do not agree.)

____ 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:

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. The following are important to me for comfort: (If you don't write specific wishes, your physician and nurses will provide the best standard of care possible.)

Cardiopulmonary Resuscitation (CPR):

My CPR choice listed below may be reconsidered by my healthcare 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 one and draw a line through the statements that you do not want.)

_____ I want CPR attempted unless my physician determines any 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.

_____ I want CPR attempted if my heart stops.

_____ I do not want CPR attempted if my heart stops, but rather, want to permit a natural death.

Other Instructions or Limitations I Want My Healthcare Agent to Follow:

If it is possible, when I am Nearing My Death and Cannot Speak, I Want My Friends and Family to Know I have the Following Thoughts and Feelings:

If I am Nearing My Death, I Want the Following: (List the type of care, ceremonies, etc. that would make dying more meaningful for you.)

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

I ask that my healthcare agent make reasonable attempts to include the following persons in my healthcare decisions if there is time: _____

_____

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):

_____

Please attempt to notify them.

Upon My Death:

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

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 with future healthcare 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.

Donations of My Organs or Tissue: (Examples of organs are kidney, liver, heart, lung; examples of tissue are eye, skin, bone, heart valve.)

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

_____ I consent to donate only the following organs or parts if possible (name the specific organs or tissue) _____

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

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

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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 (contact the Advance Directives Coordinator for a notarization form).
I am thinking clearly; I agree with everything that is written in this document and I have made this document willingly.

_____ _____
My signature (or my signature signed by the person named below) Date

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

_____
Signature of the person who I asked 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 to be the individual identified in the 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 I 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 related to the person signing this document by blood, marriage or adoption.**
- not a healthcare agent appointed by the person signing this document.
- not directly financially responsible for the person's healthcare.
- not a healthcare provider directly serving the person at this time.
- not an employee (other than a social worker or chaplain) of a healthcare 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:

_____ _____
Signature Date

_____
Print name

_____
Address City/State

Witness number 2:

_____ _____
Signature Date

_____
Print name

_____
Address City/State

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