

# Advance Directives

Advance directives are instructions specifying what actions should be taken for your health care in the event that you are no longer able to make decisions for yourself.

## ■ Your Right to Direct Your Future Health Needs

This booklet provides answers to commonly asked questions about advance directives.

## ■ Power of Attorney for Health Care Form

The State of Wisconsin or Illinois Statutory Short form should be completed, signed, witnessed and dated in order to appoint your health agent. Your health agent is the individual who will make medical decisions for you should you become incapable of making them for yourself. Legal counsel is not required to complete this form.

Monroe Clinic encourages the use of the Power of Attorney for Health Care form, instead of the Living Will form, because it is more comprehensive.

*Important note: If you change or revoke your Power of Attorney for Health Care, it is your responsibility to notify Monroe Clinic or your physician in order for us to have the most up-to-date form on file.*

■ **Mailing** Mail a copy of your Power of Attorney for Health Care to Monroe Clinic, attention medical records, at the address listed below. We will file copies of the document in both your outpatient and inpatient charts.

Monroe Clinic  
Clinic Medical Records Service/Clinic/Ad  
515 22<sup>nd</sup> Avenue  
Monroe, WI 53566

*For more information about completing advance directives, call Monroe Clinic's social services at 608-324-1172.*

# **YOUR RIGHT TO DIRECT YOUR FUTURE HEALTH NEEDS**

**Who Will Make  
Your Medical Decisions  
When You Can't?**

**Wisconsin Department of Health and Family Services  
Division of Disability and Elder Services  
Bureau of Quality Assurance**

**PDE-2025 (Rev. 10-03)**

You have the right to make decisions about your health care. This includes the right to accept or refuse medical or surgical treatment. You also have the right to plan and direct the types of health care you may receive in the event you become unable to express your wishes. You can do this by making an “advance directive.”

### **WHAT IS AN ADVANCE DIRECTIVE?**

An advance directive describes, in writing, your choices about the treatments you want or do not want or about how health care decisions should be made for you if you become incapacitated and cannot express your wishes.

An advance directive expresses *your* personal wishes, beliefs and values. When you make an advance directive, you should consider issues like dying, living as long as possible, being kept alive on machines, being independent, and quality of life. Addressing these issues may be difficult but it is necessary if you want others to follow your wishes.

### **WHO CAN MAKE AN ADVANCE DIRECTIVE?**

In Wisconsin, if you are 18 years of age or older and of “sound mind,” you can make an advance directive.

### **WHY SHOULD I MAKE AN ADVANCE DIRECTIVE?**

An advance directive speaks for you when you are unable to speak for yourself.

### **HOW DO I MAKE AN ADVANCE DIRECTIVE?**

There are three ways to make a formal advance directive in Wisconsin. You can complete either a *living will* or a *power of attorney for health care* document. These forms may be available from your health care provider or can be obtained from the Division of Public Health via <http://dhfs.wisconsin.gov/forms/AdvDirectives/index.htm>. You do not need an attorney to complete these forms. However, two persons must witness your signature. The forms describe who may or may not be a witness.

A third way to express your wishes is to have a legal document drafted by your attorney and appropriately witnessed.

### **WHAT IS A LIVING WILL?**

A living will informs your physician regarding your preferences or wishes about life-sustaining measures to be used when you are near death or in a persistent vegetative state.

The life-sustaining measures mentioned in the living will include treatments or machines that keep your heart, lungs, or kidneys functioning when they are unable to do so on their own.

A living will goes into effect only when two physicians, one of whom is your attending physician, agree in writing that you are either near death or are in a persistent vegetative state that cannot be reversed and are unable to understand or express your health care choices.

## **WHAT IS A POWER OF ATTORNEY FOR HEALTH CARE?**

The power of attorney for health care is a document in which you appoint another person (a “health care agent”) to make health care decisions for you in the event that you are not capable of making them yourself. A health care agent can make a wide range of health care decisions for you, such as whether or not you should have an operation, receive certain medications, or be placed on a life support system. In some areas of health care your health care agent is not allowed to make decisions for you unless you give him or her specific authority in those areas when you complete the form. These areas are admission to long term care facilities, limitations on mental health treatment, health care decisions for pregnant women, pregnancy care and provision of a feeding tube.

Your health care agent will make decisions for you based upon your directions, his or her knowledge about you and your wishes, and his or her opinion about what is best for you.

It is important to choose someone who knows you well and to discuss your treatment preferences with him or her in advance.

You can also include specific instructions about the type of treatments you want or do not want, e.g., surgery, when you complete the form.

A power of attorney for health care goes into effect only when two physicians, or a physician and a psychologist, agree in writing that you can no longer understand your treatment options or express your health care choices to others.

## **WHAT IS THE DIFFERENCE BETWEEN A LIVING WILL AND A POWER OF ATTORNEY FOR HEALTH CARE?**

A living will goes into effect only when your death is very near or when you are in a persistent vegetative state and you have lost the ability to make medical decisions. It deals only with the use or non-use of life sustaining measures.

A power of attorney for health care goes into effect when you are incapacitated and can no longer make health care decisions but you do not have to be close to death or in a vegetative state. The power of attorney for health care also allows another person to speak for you and make health care decisions for you that are not limited to life-sustaining measures. The type of decisions this person can make depends upon how you complete the form.

## **SHOULD I HAVE BOTH A LIVING WILL AND A POWER OF ATTORNEY FOR HEALTH CARE?**

It is not necessary to have both a living will and a power of attorney for health care. If you do have both documents, you should make sure they do not conflict.

## **WHAT IF I CHANGE MY MIND?**

You can cancel or replace a living will or a power of attorney for health care at any time by expressing this verbally or in writing to your physician or health care provider. The different ways you can do this are also explained in the letter that accompanies the forms you complete.

## **DOES MY HEALTH CARE PROVIDER HAVE TO**

## **FOLLOW MY ADVANCE DIRECTIVES?**

Some health care providers and physicians may have policies or beliefs that prohibit them from honoring certain wishes made in advance directives. It is important to discuss your wishes with them in advance to determine if they will honor your advance directives. If a physician or provider is unwilling to honor your wishes, the physician or provider must make a good faith effort to refer you to a physician or provider who will meet your needs.

## **WHAT HAPPENS IF I DON'T MAKE AN ADVANCE DIRECTIVE?**

You will receive medical care if you do not make an advance directive. However, there is a greater chance you will not receive the types of care and treatments you want if you have not made an advance directive.

If you cannot speak for yourself and have not made an advance directive, a physician will generally look to your family, friends, or clergy for decisions about your care. If the physician or health care facility is unsure, or if your family is in disagreement about the decision, they may ask courts to appoint a person (a guardian) who will make decisions for you.

## **WHERE SHOULD I KEEP MY ADVANCE DIRECTIVE?**

You should keep your advance directive in a safe place where you and others can easily find it. (Do not keep it in a bank safe deposit box.) You should make sure your family members and your attorney, if you have one, know you have made an advance directive and know where it is located. You should also ask your physician and your other health care providers to make your advance directive part of your permanent medical record.

## **I HAVE SOME QUESTIONS. WHO CAN ANSWER THEM OR GIVE ME ADDITIONAL HELP?**

Your physician or other health care providers can help you understand your health needs and the options for treating these needs. They can answer questions about advance directives.

You can also contact your attorney or the following agencies, if you have questions about advance directives.

Wisconsin Division of Public Health  
Living Will/Power of Attorney  
P.O. Box 2659  
Madison WI 53701-0309  
(608) 266-1251

To request a living will or power of attorney for health care form, send a business size, self-addressed, stamped envelope to the address at the left.

<http://dhfs.wisconsin.gov/forms/AdvDirectives/index.htm>

Wisconsin Guardianship Support Center  
2850 Dairy Dr., Suite 100  
Madison WI 53718  
608-224-0606  
800-488-2596  
[guardian@cwag.org](mailto:guardian@cwag.org)  
[www.cwag.org](http://www.cwag.org)

For questions about Powers of Attorney for Health Care and Living Wills.

To request a copy of "Planning for Future Health Care Decision-Making Do-it-Yourself Packet," send \$2.00 with your name and address to the address on the left.

Wisconsin Board on Aging and Long Term Care  
(Ombudsman Program)  
1402 Pankratz St.  
Madison WI 53704  
(608) 266-8944  
<http://longtermcare.state.wi.us/home/Ombudsman.htm>

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**DEPARTMENT OF HEALTH AND FAMILY SERVICES**  
**Division of Disability and Elder Services**  
**Bureau of Quality Assurance Offices and Addresses**

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**Madison/Southern Regional Office**  
Bureau of Quality Assurance  
2917 International Lane, Suite 210  
MADISON WI 53704  
Reg. Field Operations Director  
(608) 243-2374  
Office FAX No. (608) 243-2389

**Eau Claire/Western Regional Office**  
Bureau of Quality Assurance  
610 Gibson St., Suite 1  
EAU CLAIRE WI 54701  
Regional Field Operations Director  
(715) 836-4753  
Office FAX No. (715) 836-2535

**Milwaukee/Southeastern Regional Office**  
Bureau of Quality Assurance  
819 N. 6th Street, Room 609B  
MILWAUKEE WI 53203  
Reg. Field Operations Director  
(414) 227-4908  
Office FAX No. (414) 227-4139

**Rhineland/Northern Regional Office**  
Bureau of Quality Assurance  
1853 N. Stevens, Suite B  
RHINELANDER WI 54501  
Regional Field Operations Director  
(715) 365-2802  
Office FAX No. (715) 365-2815

**Green Bay/Northeastern Regional Office**  
Bureau of Quality Assurance  
200 N. Jefferson Street, Room 211  
GREEN BAY WI 54301  
Reg. Field Operations Director  
(920) 448-5249  
Office FAX No. (414) 448-5254

**Provider Regulation and Quality Improvement Section**  
Bureau of Quality Assurance  
PO Box 2969  
MADISON WI 53701-2969  
Section Chief (608) 266-2055  
Office FAX No. (608) 267-7119

**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, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON 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.**

**POWER OF ATTORNEY FOR HEALTH CARE**

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 persons with mental retardation, 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 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 any 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 and hospital 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 employe of the health care provider, other than a chaplain or a social worker, or an employe, 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 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**

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 \_\_\_\_\_