Healthcare Directive / Power of Attorney for Healthcare

Name (First, Middle, Last)		Birth Date: (mm-dd-yyyy)
Street Address		City
State	Zip	Primary Phone

Part 1 – Appointing Your Healthcare Agent

If I am no longer able to make my own healthcare decisions, this Power of Attorney for Healthcare names the person I choose to make these choices for me.

☐ I do not wish to name a healthcare agent. Instead I have completed Part 3 of this document to guide my healthcare if I am no longer able to make my own healthcare decisions.

***Instructions for completing Part 1*:**

When appointing your healthcare agent, select someone who:

- -is at least 18 years or older
- -knows you well, who you trust and is willing to respect your views and values
- -will be an advocate for you and will act in your best interest
- -is able to make difficult decisions under stressful circumstances
- -is **NOT** one of your healthcare providers or an employee of your healthcare provider unless they are a close relative

The person I choose as my Healthcare Agent is: (please print)

Name (First, Middle, Last)		Relationship
Address	City/State	Zip
Primary Phone	Work Phone	

If this Healthcare Agent is unable or does not want to make healthcare decisions 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(s) for a Healthcare Agent is/are:

1st Alternate Agent: (please print)

Name (First, Middle, Last)		Relationship
Street Address	City/State	Zip
Primary Phone	Work Phone	

2nd Alternate Agent: (please print)

Name (First, Middle, Last)		Relationship
Street Address	City/State	Zip
Primary Phone	Work Phone	

Part 2 – General Authority of the Healthcare Agent

***Instructions for Completing Part 2*:**
Cross out and **initial** anything you **do not** want your healthcare agent to do.

I want my Healthcare Agent to:

- make choices for me about my medical care or services including tests, medications and surgery. If treatment has already been started, my healthcare agent can keep it going or have it stopped depending on my stated (or written) instructions or in my best interests.
- interpret any instruction(s) I have given in this document or given in other discussions regarding my healthcare agent's understanding of my wishes and values.
- review and release my medical records and personal files as needed for my medical care.
- arrange for my medical care and treatment in Minnesota, Wisconsin, Iowa or any other state as my healthcare agent thinks appropriate.
- determine which health professionals and organizations may take care of me.

Instructions for completing this section:
Place your **initials** in the box for "Yes", "No" or "Does Not Apply"

[Wisconsin statute requires that you make a clear choice. This means if you **do not** indicate a choice in Wisconsin, a court order is required to make the decision, not your healthcare agent.]

Agent Authority for the purpose of long-term care:

☐ **YES,** my healthcare agent has the authority to make a decision about admitting me to a nursing home or community-based residential facility (for example: assisted living) for a long-term stay.

☐ **NO,** my healthcare agent does not have the authority to admit me to a nursing home or a community-based residential facility for a long-term stay.

Agent Authority to order the withholding or withdrawal of feeding tube and intravenous (IV) hydration:

☐ **YES,** my healthcare agent has the authority to have a feeding tube or IV hydration started, stopped, continued, withheld or withdrawn from me subject to any limits I have set forth in this document.

☐ **NO,** my healthcare agent does not have the authority to have a feeding tube or IV hydration withheld or withdrawn from me.

Agent Authority to make decisions if I am pregnant:

☐ **YES,** my healthcare agent has the authority to make decisions for me if I am pregnant.

☐ **NO,** my healthcare agent does not have the authority to make decisions for me if I am pregnant.

☐ Not Applicable to me.

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Part 3 – Statement of Directives, Desires, Special Provisions or Limitations

My healthcare agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations I list here. The following are some specific instructions for my healthcare agent and/or medical provider. 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/Healthcare Directive, or my healthcare agent cannot be contacted, I want the instructions listed here to be followed based on my common law and constitutional right to direct my own healthcare.

***Instructions for Completing Part 3*:** (**initial** all that apply)
You are not required to provide any written instructions or make any selections in Part 3. If you choose not to provide any instruction, your healthcare agent will make decisions based on your oral instructions and discussions or what is considered to be in your best interest. *If you **do not** write specific wishes, your medical team will provide the best standard of care possible.*

Pain and Symptom Control:
I want medical treatments and nursing care that will make me as comfortable and free of pain as possible.

☐ I want my pain controlled even if there is a negative outcome such as my ability to think clearly or it may shorten my life.

Stopping Attempts of Life-Prolonging Treatments:
If I reach a point where my medical providers are reasonably certain that I will not regain my ability to interact meaningfully with family, friends and the world around me (I don't know who I am, who I am with, or where I am) this is my choice:

☐ I want to stop or withhold treatments that may prolong my life. These treatments include, but are not limited to: feeding tubes, blood products, IV hydration, CPR, respirator/ventilator, antibiotics.

OR

☐ I want to receive **all** treatments that may keep me alive unless my provider determines that the treatments would harm me more than help me.

Cardiopulmonary Resuscitation (CPR):
CPR is a part of basic life support which includes chest compressions and shocks to restart the heart. Based on my current health, this is my choice if my heart or breathing stops:

☐ I want CPR attempted **unless** my provider determines:
-I have a medical condition with no reasonable chance of survival with CPR.
-CPR would harm me more than help me.

OR

☐ I **do not** want CPR – let me die a natural death.

Intubation and Mechanical Ventilation:

☐ I want intubation performed as a life-saving measure if I am unable to breathe well on my own. A breathing tube is used to connect to a mechanical ventilator which performs artificial breathing. This may necessitate a need for a tracheostomy.

☐ Allow a natural death if it is determined mechanical ventilation will be necessary long term because I cannot breathe on my own despite medical treatments.

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Part 3 – Statement of Directives, Desires, Special Provisions or Limitations – continued

Upon My Death:

Autopsy *(If required by law there is no charge; if not required by law, **it is** at the expense of your estate.)*:

☐ I want an autopsy if it will help determine the cause of my death or aid in blood relative's health decisions.

OR

☐ I **do not** want an autopsy performed on my body.

Donating My Organs and Tissues (examples: kidney, liver, heart, lung, eye, skin, bone):

☐ I consent to donate my organs or tissues if I am a candidate. If possible, I only want to donate these specific organs or tissues: _____

OR

☐ I **do not** want to donate any organs or tissues.

Donating My Body to scientific research:

I have made arrangements with _____ to donate my body for scientific research. I understand I cannot be an organ or tissue donor.

Other Information and Requests:

My funeral home designation, cremation or burial plans are as follows:

_____

_____

I am a member of this (congregation, synagogue or worship group) and would like them notified of my wishes (rituals, customs, sacraments) if I am nearing death:

_____

Other instructions for personal care *(example: haircuts, dentures, glasses)* or for comfort measures *(example: music, pictures, blanket/pillows)* or for medical care *(example: blood transfusion, dialysis, etc.)*

_____

_____

_____

_____

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Part 4 – Making the Document Legal

Minnesota or **Iowa** residents may have this document signed and dated in the presence of two witnesses **OR** a Notary Public.

Wisconsin residents must have this document signed and dated in the presence of two witnesses.

I am thinking clearly; I agree with everything that is written in this document and I have signed this document willingly in the presence of two witnesses or a Notary Public.

Patient Signature	Date (mm-dd-yyyy)

I agree with everything in this document but I cannot sign my name. The person named below signed this document in my presence for me.

Signature	Date (mm-dd-yyyy)

Print Name (First, Middle, Last)

Statement of Witnesses:
I know this person to be the individual identified in the document. I believe this person to be of sound mind and at least 18 years of age. I personally witnessed the signing of this document, and I believe that it was done so voluntarily.

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

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

Witness 1

Signature	Date (mm-dd-yyyy)

Printed name (First, Middle, Last)

Address	City/State	Zip

Witness 2

Signature	Date (mm-dd-yyyy)

Printed name (First, Middle, Last)

Address	City/State	Zip

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Notarization:

Minnesota and Iowa Residents: This document may be notarized in their state, instead of having two witnesses.

Wisconsin: Notarization of this document is not legal for residents of Wisconsin.

Notary Public:

In the state of: Minnesota / Iowa (circle one)

County of _____

In my presence on (date) _____ (Name)_____

Acknowledged his or her signature on this document or acknowledged that he or she authorized the person signing this document to sign on his or her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

_____
Signature of Notary

_____
Title of Office (and rank for Military Personnel)

Notary Stamp
(required)

_____
My Commission Expires (date)

After Completing This Document:

A photo or fax copy is as legally valid as the original. Provide copies to your hospital, medical providers and healthcare agent. You may want copies to be given to close family and friends. Copies of this document have been given to the following healthcare organizations and people:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____