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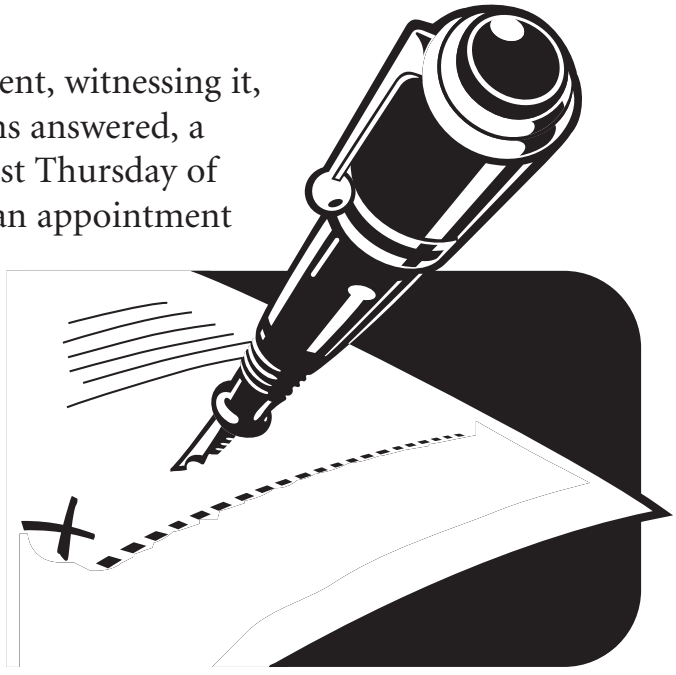
POWER OF ATTORNEY FOR HEALTHCARE

Before critical healthcare decisions need to be made, you should know about these documents.

- Living Wills
- Power of Attorney for Healthcare.

Attached to this form is a Power of Attorney for Healthcare (POAC). A Power of Attorney for Healthcare lets you name someone else to be your agent. This person can decide on treatment for you only when you can't express your wishes. But you do not have to be at the end of life. He or she could speak for you if you were in a coma but were likely to recover.

Thoughtful Thursday



If help is needed completing the document, witnessing it, or if you simply want questions/concerns answered, a trained representative is available the first Thursday of every month to help you. Please make an appointment between the hours of 12:00 noon and 4:00 pm. Each appointment is 1/2 hour in length, and forms can be completed and copies made for you in that time. If you schedule an appointment, and then cannot make the assigned date, please call and cancel your appointment, as there is always a waiting list.

To make an appointment
please call Aspirus Wausau Hospital at

715-847-2380 or
1-800-847-4707.

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Wausau, WI

Do Not Remove This Page

HOW TO COMPLETE THIS POWER OF ATTORNEY FOR HEALTH CARE

Overview

The attached is a legal document that provides a way for you to create a power of attorney for health care that will meet the basic requirements for the State of Wisconsin and guide your physician in your plan of care.

This document allows you to appoint another person to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is your health care agent. This document gives your health care agent authority to make your decisions only when you have been determined incapable by your physician(s) to make your own health care decisions. It does not give your health care agent any authority to make your financial or other business decisions.

Before completing this power of attorney for health care form, take time to read it carefully. It is also very important that you discuss your views, values, and this document with your health care agent! If you do not closely involve your health care 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.

This document must be signed in the presence of two witnesses.

Need Assistance?

If you need assistance in completing this document you may contact:

Aspirus Wausau Hospital

Call (715)847-2380 or 1-800-847-4707 for a Thoughtful Thursday appointment.

After Completing This Document

After you complete the document, make copies to be given out as follows:

- one copy for yourself;
- one copy for your health care agent and your alternate
- one copy to share and discuss with your physician
- one copy for your medical record at the hospital where you expect to be cared for
- extra copies to share with others if you wish

A copy is as legally valid as an original.

Power of Attorney for Health Care Document

Notice to the 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 a person who you would want to make health care decisions for you if you become unable to make those decisions personally. That person is known as your health care agent. It is also important to talk about your values and beliefs and what quality of life means to you with the person you specify.

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 or by creating a new document. 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 and your marriage is annulled or you are divorced after signing this document, the designation of your spouse as health care 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 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.

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF HEALTH
MAIL ADDRESS
1 WEST WILSON STREET
P.O. BOX 309
MADISON, WISCONSIN 53701-0309

Power of Attorney for Health Care
In Accordance with Wisconsin State Statutes

Developed by Aspirus Wausau Hospital, Wausau, WI

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____Phone:_____

Social Security #: (Optional) _____

Copies given to:

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

Name: _____Birthdate: _____

PART I – APPOINTING A PERSON TO MAKE MY HEALTH CARE DECISIONS WHEN I CAN NOT MAKE MY OWN HEALTH CARE DECISIONS.

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my Health Care Agent. This person will make my health care decisions when I am determined to be incapable to make them.

Instructions for Completing this Part:

When selecting someone to be your health care agent, pick someone you know well, 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. Take time to discuss this document with the person you pick to be your agent and/or alternate.

Your Health Care Agent must be at least 18 years old and should not be your health care provider or an employee of your health care provider unless they are a relative.

The person I choose as my agent and have discussed my desires with is:

Name: _____ Relationship:_____

Day Phone: _____ Evening Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature of agent (optional): _____

If this health care agent is unable or unwilling to make my choices for me, **then my alternate agent is:**

Name: _____ Relationship:_____

Day Phone: _____ Evening Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature of agent (optional): _____

Name: _____Birthdate: _____

PART II – GENERAL AUTHORITY OF THE HEALTH CARE AGENT

I want my Health Care Agent to be able to do the following subject to limitations set forth in Part III.

- Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, my Health Care Agent can keep it going or have it stopped depending upon my stated instructions or my best interests.

- Interpret any instruction I have given in this form or given in other discussions according to my Health Care Agent's understanding of my wishes and values.

- Review and release my medical records and personal files as needed for my medical care.

- Determine which health professionals and organizations provide my medical treatment.

Instructions for Completing these Sections:

Write your initials in the appropriate box in the following three sections. **If you do not mark a box, your health care agent may admit you for only short term stays for recuperative care or respite care.** If you are unable to write your initials, you may ask another person to do so.

Admission to a nursing home or community-based residential facility for purpose of long-term care. If you do not initial "yes" box, your health agent may admit you for only short term stay for recuperative care or respite care.

☐ 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/

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

If I choose "No" or do not initial a box, my agent will have to get a court order for both guardianship and protective placement before I can be admitted to a nursing home or community-based residential facility for a long term stay.

Name: _____Birthdate: _____

Order the withholding or withdrawal of feeding tube and I.V. hydration (fluids given to me through my veins).

☐ Yes, my Health Care Agent has authority to have a feeding tube or I.V. hydration withheld or withdrawn from me subject to any limits I have set forth in this document.

☐ No, my Health Care Agent does not have authority to have a feeding tube or I.V. hydration withheld or withdrawn from me. If I initial "no", feeding tubes or I.V. hydration cannot be withheld or withdrawn without a court order.

Agent authority to make decisions if I am pregnant.

☐ Yes, my Health Care Agent has authority to make decisions for me if my agent knows I am pregnant.

☐ No, my Health Care Agent does not have authority to make decisions for me if my agent knows I am pregnant. If I initial "no", health care decisions can not be made for me without a court order during my pregnancy

☐ Not applicable.

Name: _____Birthdate: _____

PART III – STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

My Health Care 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 Health Care Agent and/or physician providing my medical care. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, or my Health Care Agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own health care.

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 health care agent will make decisions based on your oral instructions or what is considered your best interest.

☐ 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 life.

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 relieve my pain and symptoms and make me more comfortable.

Cardiopulmonary Resuscitation (CPR):

☐ I want to be resuscitated.

☐ I do not want to be resuscitated.

☐ I want resuscitation unless my physician determines 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.

Name: _____Birthdate: _____

Other Instructions or Limitations I want My Health Care Agent to Follow:

_____

_____

_____

UPON MY DEATH:

Donation of My Organs or Tissue: (Initial one box)

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

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

☐ I do not consent to donate any organ or tissue.

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.

University of Wisconsin-Madison Medical School	608-262-2888
Medical College of WI-Milwaukee	414-456-8296

Autopsy: (Initial appropriate box)

☐ I would allow 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 would allow an autopsy if it can help the advancement of medicine or medical education.

☐ I do not want an autopsy performed on me.

Name: _____Birthdate: _____

PART IV – MAKING THE DOCUMENT LEGAL

Instructions for Completing this Part:

You must sign this document in the presence of two witnesses. If you cannot sign your name or write your initials, you may ask someone to do that for you.

I agree with everything that is written in this document and I have made this document willingly.

_____ _____
My Signature Date

_____
Signature of the person who I asked to write and sign this document for me.

_____
Print the name of the person who I asked to sign this document for me.

*The Witnesses **Must:***

- be at least 18 years of age
- not be a health care agent appointed by the person signing this document
- not be related to the person signing this document by blood, marriage, or adoption
- not be financially responsible for the person's health care
- not be a health care provider or an employee directly serving the person at this time (other than a social worker or chaplain)

Witness number 1: I believe this person is of sound mind and is signing this voluntarily.

_____ _____
Signature Date

_____
Print Name

_____
Address

Witness number 2: I believe this person is of sound mind and is signing this voluntarily.

_____ _____
Signature Date

_____
Print Name

_____
Address

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MEDICAL TERMS

CARDIOPULMONARY RESUSCITATION (CPR):
Life-saving procedures that include compression over the breast bone to maintain blood flow, electric shock to restart the heart, placing a breathing tube in the windpipe so that oxygen can be sent to the lungs, and using medicines to restore blood pressure.

DO NOT RESUSCITATE (DNR):
Physician orders written so the CPR will not be used if a person's heart or breathing stops. DNR does not mean "no care". Emergency personnel will make every effort to provide comfort measures, which may include: oxygen, pain medication, clearing the airway and providing emotional support to the patient and family.

FEEDING TUBE:
A tube through which fluids or nutrition is administered through the vein, stomach, nose or mouth.

RESPIRATOR/VENTILATOR:
A medical machine used to assist with breathing when a person cannot breathe independently.

ANTIBIOTICS:
Medications used to treat infections.

AUTOPSY:
A medical examination done after death in order to confirm or determine the cause of death.

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DEFINITION OF TERMS

ADVANCE DIRECTIVE:
A document indicating a person's wishes regarding health care decisions when the person is unable to communicate those decisions.

LIVING WILL:
Written instructions that tell physicians and family members what life-sustaining treatment a person does, or does not want, if one becomes unable to make decisions at some future time.

POWER OF ATTORNEY FOR HEALTH CARE:
A legal document in which one person (called a principal) appoints someone else (called an agent) to make health care decisions in the event he/she become incapable of making decisions. The Power of Attorney document is more comprehensive than the Living Will & is the preferred document in the state of Wisconsin.

LEGAL GUARDIAN:
A person appointed by a judge to make personal decisions for another person (called a ward) including consent to, or refusal of medical treatment.

INCAPACITY:
The inability to receive & evaluate information effectively, or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions.