



# WISCONSIN Advance Directive Planning for Important Healthcare Decisions

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## PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

1. Read all the instructions as they will give you specific information about the requirements in Wisconsin.
2. Refer to the Glossary located in Appendix A, page 14, if any of the terms in this document are unclear.

## ACTION STEPS

3. You may want to make a copy of these forms before you start so you will have a clean copy if you need to start over.
4. Talk with your family, friends, and doctors about your advance directive. Be sure the person you decide to make decisions for you knows your wishes.
5. Once the form is completed and you have signed it, make a copy of the form and give it to the person you have decided to make decisions for you, along with your family, friends, healthcare providers and/or faith leaders, so the form is available in the event of an emergency.

If you have questions or need help in preparing your advance directive or about what you should do with it after you have completed it, please refer to the Wisconsin contacts for Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives, located in Appendix B.

## **INTRODUCTION TO YOUR WISCONSIN ADVANCE DIRECTIVE**

This packet contains two **(2) LEGAL DOCUMENTS** that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Wisconsin Power of Attorney for Healthcare (information & form)** lets you name someone to make decisions about your medical care—including decisions about life support—if two physicians (or one physician and one psychologist) determine that you are not able to make your own healthcare decisions. The Power of Attorney for Healthcare is very useful because it names someone to speak for you any time you are not able to make your own healthcare decisions, not only at the end of life.

2. The **Wisconsin Declaration to Physicians (information & form)** is your Wisconsin living will. It lets you give your wishes about the denial or removal of life-sustaining procedures or feeding tubes in the event that you enter into a persistent vegetative state or develop a terminal condition. Although the Declaration to Physicians will be effective in most circumstances, it may not authorize the denial or removal of life-sustaining procedures or feeding tubes if your doctor determines that such denial or removal will cause you pain or discomfort.

**Note:** These documents will be legally binding only if you are a competent adult who is at least eighteen years old.

## **COMPLETING YOUR WISCONSIN POWER OF ATTORNEY FOR HEALTHCARE**

### **Who should I appoint as my Healthcare Agent?**

Your healthcare agent is the person you decide to make decisions about your medical care if you become unable to make those decisions yourself. Your healthcare agent may be a family member or a close friend whom you trust to make important decisions. The person you name as your healthcare agent should clearly know your wishes and be willing to accept the responsibility of making medical decisions for you.

Unless he or she is related to you, the person you appoint as your healthcare agent **cannot** be:

- your treating healthcare provider;
- an employee of your treating healthcare provider;
- an employee of a healthcare facility in which you reside or are a patient; or
- a spouse of any of the above.

You can name another person as your alternate healthcare agent. The alternate will step in if the first person you name as your healthcare agent is not able or, not willing to act for you.

### **How do I make my Wisconsin Power of Attorney for Healthcare legal?**

The law requires that you date and sign your Power of Attorney for Healthcare in the presence of two adult witnesses. If you are physically not able to sign, another adult can sign for you at your direction and in your presence. The two witnesses must sign a statement stating that you are of sound mind and that you signed the Power of Attorney for Healthcare of your own free will.

These witnesses **cannot be**:

- Related to you by blood, marriage or adoption;
- Persons who know they are entitled to, or have a claim against, any part of your estate;
- Directly financially responsible for your healthcare;
- Your healthcare provider;
- An employee of your healthcare provider, other than a chaplain or a social worker;
- An employee of an inpatient healthcare facility in which you are a patient, other than a chaplain or a social worker; or
- Your healthcare agent.

Note: You do not need to notarize your Wisconsin Power of Attorney for Healthcare.

### **Should I add personal instructions to my Wisconsin Power of Attorney for Healthcare?**

One of the best reasons for naming a healthcare agent is to have someone who can act as your medical condition changes. If you add instructions, you might unintentionally limit your healthcare agent's power to act in your best interest.

Talk with your healthcare agent about your future medical care and explain what you think to be an acceptable "quality of life." If you want to record your wishes regarding the denial or removal of life-sustaining procedures or feeding tubes, you should use your Wisconsin Declaration to Physicians (the living will).

### **What if I change my mind?**

You may revoke your Wisconsin Power of Attorney for Healthcare at any time, by:

- Canceling, burning, tearing or otherwise destroying the document;
- Signing and dating a written statement of your intent to cancel your Wisconsin Power of Attorney for Healthcare;
- Expressing your intent to cancel your Wisconsin Power of Attorney for Healthcare verbally in front of two witnesses; or
- Executing another Wisconsin Power of Attorney for Healthcare.

If you use this document to donate or refuse to donate an organ, you may revoke or change any organ donation that you make by crossing out the anatomical gifts provision in the Wisconsin Power of Attorney for Healthcare.

# 1. WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE INFORMATION

**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 the person whom you want to make health care decisions for you, if you are unable to make those decisions yourself. 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 who you have specified as your health care agent. 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 not aware 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 health care agent broad powers to make health care decisions for you. It takes away 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 cancel 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 cancelled in the presence of two (2) witnesses. If you cancel, you should notify your health care agent, your health care providers and any other person to whom you have given a copy of this document. If your agent is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

You may also use this document to donate or refuse to donate an organ upon your death. If you use this document to donate or refuse to donate an organ, this document revokes any prior document of donation that you may have made. You may revoke or change any organ donation 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 doctor.

**WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE  
FORM**

Document made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
(date) (month) (year)

**CREATION OF POWER OF ATTORNEY FOR HEALTH CARE**

I, \_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(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)

\_\_\_\_\_  
(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 two (2) physicians or a physician and a psychologist who have personally examined me sign a statement that specifically states 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 knows my wishes 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 mentally retarded, 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 other 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", my health care agent may only admit me for short-term stays for recuperative care or respite care.

✓ PROVISION OF A FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube denied or removed 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 food or water denied or removed from me unless provision of the food or water is medically contraindicated.

Deny or remove 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 removed 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 conditions or limitations that I give. The following are specific desires, conditions 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 document(s) 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 employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the declaring 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 No. 1: (Print) Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
  
Signature \_\_\_\_\_

Witness No. 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.

\_\_\_\_\_ has discussed his or her desires regarding health care (name of principal) decisions with me.

Agent’s signature \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Alternate agent’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 is executed as provided in chapter 155 of the Wisconsin Statutes.

**WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE**

**ANATOMICAL GIFTS  
(OPTIONAL)**

Upon my death:

\_\_\_\_\_ I wish to donate only the following organs or parts:

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(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.

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 of principal)

\_\_\_\_\_  
(Date)

# **WISCONSIN DECLARATION TO PHYSICIANS (LIVING WILL)** INFORMATION

## **COMPLETING YOUR WISCONSIN DECLARATION TO PHYSICIANS**

### **How do I make my Wisconsin Declaration to Physicians legal?**

The law requires that you sign your Declaration in the presence of two adult witnesses. If you are physically unable to sign, another adult can sign at your express direction and in your presence. The two witnesses must sign a statement acknowledging that they personally know you and believe you to be of sound mind.

These witnesses **cannot** be:

- Related to you by blood, marriage or adoption;
- Persons who know they are entitled to or have a claim on any portion of your estate;
- Directly financially responsible for your healthcare;
- Your attending healthcare provider or an employee of your attending healthcare provider, other than a chaplain or a social worker; or
- An employee of an inpatient healthcare facility in which you are a patient, other than a chaplain or a social worker.

Note: You do not need to notarize your Wisconsin Declaration to Physicians.

### **Can I add personal instructions to my Declaration to Physicians?**

One of the strongest reasons for executing a Declaration to Physicians is to have a clear statement of your intentions regarding the denial or removal of life-sustaining procedures or feeding tubes. If you add instructions, you might unintentionally restrict the effectiveness of your Declaration.

If you have appointed a healthcare agent, talk about your future medical care and describe what you consider to be an acceptable “quality of life.”

### **What if I change my mind?**

You may revoke your Declaration to Physicians at any time by:

- Canceling, defacing, burning, tearing or otherwise destroying the document;
- Signing and dating a written revocation;
- Executing a subsequent Declaration to Physicians; or
- Verbally expressing your intent to cancel the Declaration. A verbal cancellation only becomes effective if you or a person acting on your behalf notify your doctor of the cancellation.

### **What other important facts should I know?**

A pregnant patient’s Declaration to Physicians will not be honored during pregnancy due to restrictions in the state law.

**WISCONSIN DECLARATION TO PHYSICIANS (LIVING WILL)**

**FORM**

I, \_\_\_\_\_, (print name) being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a **TERMINAL CONDITION**, as determined by two physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

- YES, I want feeding tubes used if I have a terminal condition.
- NO, I do not want feeding tubes used if I have a terminal condition.

**(If you have not checked either box, feeding tubes will be used.)**

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by two physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures:

- YES, I want life-sustaining procedures used if I am in a persistent vegetative state.
- NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

**(If you have not checked either box, life-sustaining procedures will be used.)**

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by two physicians who have personally examined me, the following are my directions regarding the use of feeding tubes:

- YES, I want feeding tubes used if I am in a persistent vegetative state.
- NO, I do not want feeding tubes if I am in a persistent vegetative state.

**(If you have not checked either box, feeding tubes will be used.)**

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

**ATTENTION: YOU AND THE TWO WITNESSES MUST SIGN THE DOCUMENT AT THE SAME TIME.**

Signed \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness signature \_\_\_\_\_ Date signed \_\_\_\_\_

Print Name \_\_\_\_\_

Witness signature \_\_\_\_\_ Date signed \_\_\_\_\_

Print Name \_\_\_\_\_

### DIRECTIVES TO ATTENDING PHYSICIANS

1. This document authorizes the denial or removal of life sustaining procedures or of feeding tubes when two physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law the patient's stated desires must be followed unless you believe the denial or removal of life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot meet the terms of this document, you must make a good faith attempt to transfer the patient to another physician who will meet the terms. Refusal or failure to do so represents unprofessional conduct.

4. If you know that the patient is pregnant, this document shall have no effect during her pregnancy.

### LOCATION OF COPIES

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

_____	_____	_____
_____	_____	_____
_____	_____	_____

## **You Have Filled Out Your Advance Directive, Now What?**

1. Your Wisconsin Declaration to Physicians and Wisconsin Power of Attorney for Healthcare are important legal documents. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give a copy of the signed original document to the following: your healthcare agent and alternate healthcare agent; your doctor(s); your family; close friends; your clergy; and anyone who might become involved in your healthcare. If you enter a nursing home or hospital, have copies of your document placed in your medical records. You may also file the documents with the register in probate of the county in which you reside.
3. Be sure to talk to your healthcare agent and alternate, your doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
5. Remember, you can always cancel one or both of your Wisconsin documents. If you cancel your documents, make sure you notify your agent, alternate agents, your family and your doctors.
6. Be aware that your Wisconsin documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your doctor and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information.

**It is the member's responsibility to send these forms  
to the appropriate provider office(s).**

**Physicians Plus Insurance Corporation WILL NOT  
distribute these forms to provider offices.**

## **APPENDIX A - GLOSSARY**

**Advance directive** - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

**Artificial nutrition and hydration** – Artificial nutrition and hydration supplements replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

**Brain death** – The irreversible loss of all brain function. Most states legally define death to include brain death.

**Capacity** - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

**Cardiopulmonary resuscitation** - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

**Do-Not-Resuscitate (DNR) order** - A DNR order is a physician's written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

**Emergency Medical Services (EMS):** A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

**Healthcare agent:** The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

**Hospice** - Considered being the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the person's loved ones as well.

**Intubation-** Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

**Life-sustaining treatment** - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

**Living will** - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a “directive to physicians”, “healthcare declaration,” or “medical directive.”

**Mechanical ventilation** - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

**Medical power of attorney** - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a healthcare agent, surrogate, attorney-in-fact or proxy.

**Palliative care** - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.

**Power of attorney** – A legal document allowing one person to act in a legal matter on another’s behalf regarding to financial or real estate transactions.

**Respiratory arrest:** The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

**Surrogate decision-making** - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

**Ventilator** – A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

**Withholding or withdrawing treatment** - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

## **APPENDIX B**

### **Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives**

#### **LEGAL SERVICES**

Legal Action of Wisconsin, Inc. provides civil legal services for low-income Wisconsin individuals of all ages. If Legal Advisors are unable to assist you they will connect you to another legal referral in your area.

Individuals over the age of 60 with low to moderate incomes can receive free, over the phone legal information and advice about most issues, including:

- Healthcare
- Bankruptcy
- Social Security
- Probate
- Public Benefits and more
- Must be over 60
- Free for individuals with low to moderate incomes

**To find out about services, legal information and resources offered through Legal Action of Wisconsin visit their website: <http://www.legalaction.org/legalservices.htm> or Call: 414-278-1222 or 414-278-7722.**

#### **END-OF-LIFE SERVICES**

The Wisconsin Area Agency on Aging (AAA) can connect individuals over the age of 60 with services and programs available for individuals in their region. AAA resources and services include, but are not limited to:

- Housing problems
- Food Stamps
- Transportation and meals
- Medicare and Medicaid
- Consumer problems and more
- Must be over 60
- Free for individuals with low to moderate incomes

**Visit their website for more information about services and to locate AAA in your region: <http://dhfs.wisconsin.gov/aging/index.htm> or Call: 1-608-266-2536.**