STEP BY STEP INSTRUCTIONS FOR COMPLETING THE WISCONSIN "DECLARATION TO PHYSICIANS" (LIVING WILL)

STEP 1: BEFORE FILLING IT OUT – Read the entire document carefully. Be sure you understand what it means and that you are comfortable with its language. Also, if you are or have already completed a Power of Attorney for Health Care, consider whether you need this document as well since these same issues could be addressed in the Power of Attorney for Health Care. If you determine you do need or want this document proceed to Step 2.

STEP 2: FILLING IT OUT – Print your name in the first blank and then proceed to the check-offs. Paragraph 2 addresses the question of use of feeding tubes if you have a terminal condition. Paragraph 3 addresses first the question of life-sustaining procedures and then, separately, feeding tubes, if you are in a persistent vegetative state.

You are now ready for the signing. You and your two witnesses must be together. The witness may not be a relative by blood or marriage nor an employee of your health care provider or your health care provider's spouse. (EXCEPTION: Hospital social workers may witness these documents).

STEP 3: AFTER IT IS COMPLETED – Make several copies of the form. Give the original to your physician (if you have a regular physician, as opposed to a clinic), discuss your choices, and ask him or her to honor them if the situations ever arise. Discuss and consider giving copies of the document to family members and ask them, too, to honor your choices, as indicated on the form. Put one copy in a safe place at home (not in a locked bank box) and give a copy to your hospital. You may also, for a small fee, file a copy with the Register-in-Probate in your county's Probate Court Office.

Coalition of Wisconsin Aging Groups

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State of Wisconsin

Department of Health and Family Services

DIVISION OF PUBLIC HEALTH

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To Whom It May Concern:

Enclosed is the Declaration to Physicians (Living Will) form, which you requested. This form makes it possible for adults in Wisconsin to state their preferences for life-sustaining procedures and feeding tubes in the event the person is in a terminal condition or persistent vegetative state.

Be sure to read both sides of the form carefully and understand it before you complete and sign it.

The withholding or withdrawal of any medication, life-sustaining procedure or feeding tube may not be made if the attending physician advises that doing so will cause pain or reduce comfort and the pain or discomfort cannot be alleviated through pain relief measures.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage or adoption and not directly financially responsible for your health care. Witnesses may also not be persons who know they are entitled to or have a claim on any portion of your estate. A witness cannot be a health care provider who is serving you at the time the document is signed, an employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or social worker, of an inpatient health care facility in which you are a patient. Valid witnesses acting in good faith are immune from civil or criminal liability.

You should make relatives and friends aware that you have signed the document and the location where it is kept. A signed form may be kept in a safe, easily accessible place until needed. The document may but is not required to be filed for safekeeping, for a fee, with the register in probate of your county of residence. The fee for this has been set by State Statute at $8.00.

You are responsible for notifying your attending physician of the existence of the declaration. An attending physician who is notified shall make the declaration part of your medical records. A declaration that is in its original form or is a legible photocopy or electronic facsimile copy is presumed to be valid.

If you have both a Declaration to Physicians and a Power of Attorney for Health Care, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

Up to four copies of the Declaration to Physicians are available free to anyone to sends a stamped, self-addressed business size envelop to: Living Will, Division of Health, P.O. Box 309, Madison, Wisconsin 53701-0309. You may obtain additional copies of the form by using a photocopy machine or other printing method to reproduce it.

If you have questions about the availability of the Declaration to Physicians (Living Will) form or obtaining larger quantities of the form, you may contact Sherry Kasper-Mohrbacher by writing to the Division of Health or by telephoning 608-266-8475.

INSTRUCTIONS FOR DECLARATION TO PHYSICIANS FORM

A. Definitions

"Declaration" means a written, witnessed document voluntarily executed by the declarant under State Statute 154.03(1), but is not limited in form or substance to that provided in State Statute 154.03(2).

"Department" means department of health and family services.

"Feeding tube" means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of a qualified patient.

"Terminal condition" means an incurable condition caused by injury or illness that reasonable medical judgement finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

"Persistent vegetative state" means a condition that reasonable medical judgement finds constitutes complete and irreversible loss of all the functions of the cerebral cortex and results in a complete, chronic and irreversible cessation of all cognitive functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue.

"Qualified patient" means a declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by 2 physicians, one of whom is the attending physician, who have personally examined the declarant.

"Attending physician" means a physician licensed under State Statute Chapter 448 who has primary responsibility for the treatment and care of the patient.

"Health care professional" means a person licensed, certified or registered under State Statutes Chapters 441, 448 or 455.

"Inpatient health care facility" has the meaning provided under State Statute 50.135(1) and includes community-based residential facilities as defined in State Statute 50.01(1g).

"Life-sustaining procedure" means any medical procedure or intervention that, in the judgement of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient.

"Life-sustaining procedure" includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but does not include (a) The alleviation of pain by administering medication or by performing an medical procedure. (b) The provision of nutrition or hydration.

B. Procedures for signing Declarations

A declaration must be signed by the declarant in the presence of 2 witnesses. If the declarant is physically unable to sign a declaration, the declaration must be signed in the declarant's name by one of the witnesses or some other person at the declarant's express direction and in his or her presence; such a proxy signing shall either take place or be acknowledged by the declarant in the presence of 2 witnesses.

C. Effect of Declaration

The desires of a qualified patient who is competent supersede the effect of the declaration at all times. If a qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures or feeding tubes a declaration executed under this chapter is presumed to be valid.

D. Revocation of Declaration

A declaration may be revoked at any time by the declarant by any of the following methods:

1) By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the declarant or by some person who is directed by the declarant and who acts in the presence of the declarant.
2) By a written revocation of the declarant expressing the intent to revoke signed and dated by the declarant.
3) By a verbal expression by the declarant of his or her intent to revoke the declaration, but only if the declarant or a person acting on behalf of the declarant notifies the attending physician of the revocation.
4) By executing a subsequent declaration.

The attending physician shall record in the declarant's medical records the time, date and place of the revocation and time, date and place, if different, that he or she was notified of the revocation.

E. Liabilities

No physician, inpatient health care facility or health care professional acting under direction of a physician my be held criminally liable or civilly liable, or charged with unprofessional conduct of any of the following:

1) Participating in the withholding or withdrawal of life-sustaining procedures or feeding tubes under ch. 154, subchapter II.
2) Failing to act upon a revocation unless the person or facility has actual knowledge of the revocation.
3) Failing to comply with a declaration, except that failure by a physician to comply with a declaration of a qualified patient constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the patient to another physician who will comply with the declaration.

DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 0060 (Rev. 4/96)

Effective Date
April 6, 1996
S. 154.03(1),(2)

PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT
BEFORE YOU COMPLETE AND SIGN IT

DECLARATION TO PHYSICIANS
(WISCONSIN LIVING WILL)

I, ____, 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 2 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 2 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 2 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 used 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 2 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 PHYSICIAN

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when 2 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 that withholding or withdrawing 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 comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

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

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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:

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