MEC 11-21-11

The Conversation:

A Panel Discussion On Medical Decision-Making In The Real World

About the Presenters...

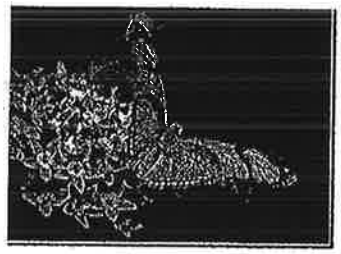
Toby C. Campbell, M.D., MSCI is an Assistant Professor of Medicine at the University of Wisconsin. He is a Medical Oncologist specializing in lung cancer, chief of the Palliative Care program, and directs the fellowship in hospice and palliative medicine. He completed medical school at the University of Virginia, residency at the University of Wisconsin, and fellowship training at Northwestern University. He has received numerous compassionate care and research awards and the focus of his research is on communication education and symptom management in cancer patients.

Denise M. Gloede, RN, BSN, CHPN is currently the VP of Access at Agrace HospiceCare. Denise oversees admissions, clinical outreach, and health system partner relationships. Ms. Gloede served as the Inpatient Unit Director at Agrace for seven years. In addition to hospice, she has experience in home health care, assisted living, community based waiver programs, and inpatient hospital care. Denise lives in Madison with her husband, Carl, and her three children.

Richard J. Langer is a partner in the law firm of Michael Best & Friedrich, LLP, where he concentrates his practice in the areas of estate planning, estate administration, trusts, and marital property. He received his undergraduate degree, *magna cum laude*, in aeronautical engineering from the University of Illinois and his law degree, *cum laude*, from the University of Wisconsin Law School, where he was a member of the *Wisconsin Law Review* and the Order of Coif. He is a Fellow in the American College of Trust and Estate Counsel, a member of the Madison Estate Council, the American Bar Association, the State Bar of Wisconsin (Real Property, Probate and Trust Law Section), and Dane County Bar Association. He is a contributing author and co-author of several publications. In addition to his private practice, Mr. Langer has extensive teaching experience as a lecturer to the University of Wisconsin Law School and various bar organizations in estate planning topics, including Marital Property Reform. Mr. Langer is also listed in The Best Lawyers in America and Who's Who in American Law.

"We are like butterflies who flutter for a day, and think it is forever."

–Dr. Carl Sagan



'The Conversation' Is About:

- The kind of medical treatment you want or don't want
- The person you want making medical treatment decisions for you if you become incapacitated

'The Conversation' Is About:

- How comfortable you want to be
- How you want people to treat you
- What you want your loved ones to know

When Should You Have 'The Conversation'

- Multiple times
  - When you are at the end of your life
  - When you are facing major medical issues during your life
  - When you are planning your estate

Why Have 'The Conversation'?

- It empowers you to clearly establish the kind of medical treatment you want or don't want .... And helps avoid bad outcomes
- It empowers your surrogate to carry out your wishes

Why Have 'The Conversation'?

- It eliminates the burden on your family to make decisions with little or no direction from you
- It eliminates the likelihood of family disputes

The End

"A man should not leave this earth with unfinished business. He should live each day as if it was a pre-flight check. He should ask each morning, am I prepared to lift-off?"

-Diane Frolov and Andrew Schneide
Northern Exposure, All is Vanity, 1991

Rick's Mom

If I ever...

Make sure...

Don't let me...

Take care of...

Dorothy's Gifts

Prepared...

Honored wishes...

Time well spent...

Eased his pain...

Not Me

"I don't want to achieve immortality through my work...I want to achieve it through not dying."

–Woody Allen

Brian

I'm healthy...

I'll die in my sleep...

Busy living...

...

Brian's Family

Do everything or...

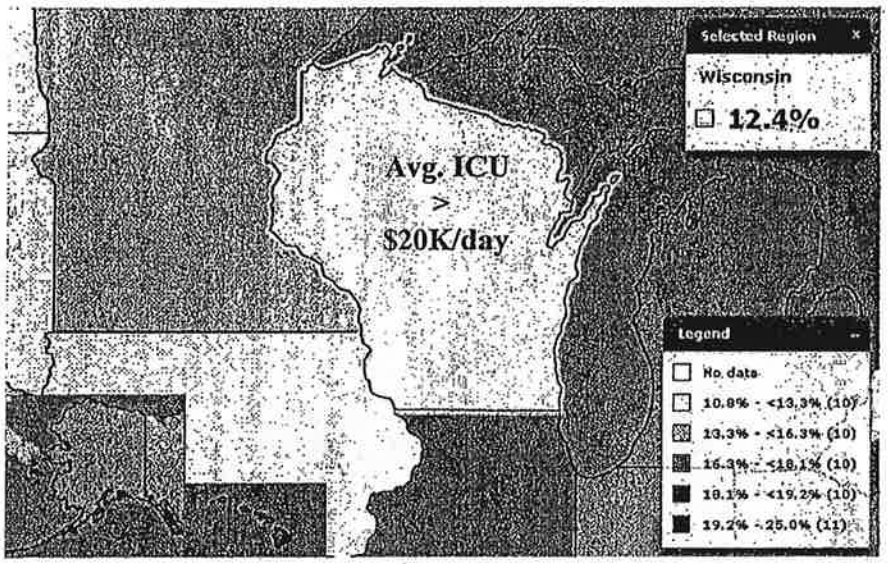
Yes...no...yes...no...

Bear the pain...

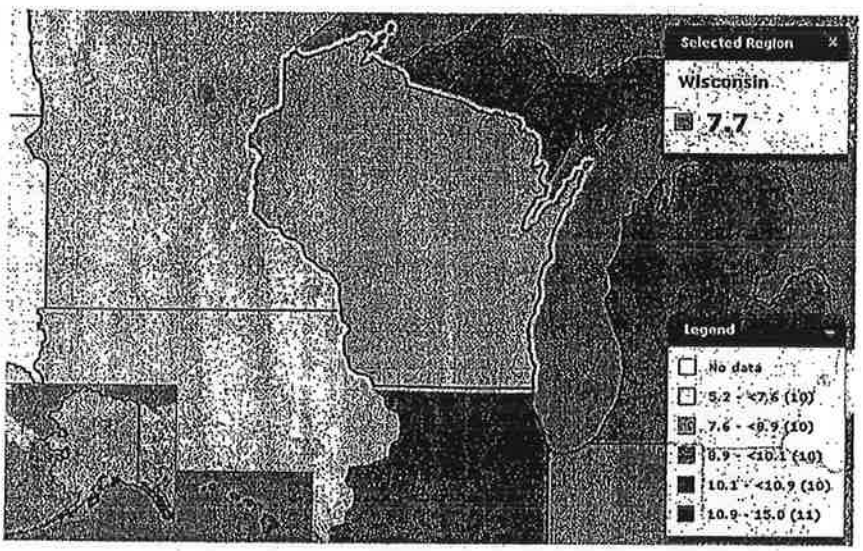
No time for goodbye...


What's
Happening
in
Wisconsin?

PERCENT OF DEATHS ASSOCIATED WITH ICU ADMISSION
(YEAR: 2003–2007)



INPATIENT DAYS PER DECEDENT
DURING THE LAST SIX MONTHS OF LIFE
(YEAR: 2007)



EOL Experience in an ICU

- Ventilators
- Invasive Procedures
- High Tech Environment
- Limited Visitation Hours
- Noise Pollution
- Smells
- Tubes, bells, whistles, specialists...
- Only ONE CHAIR (maybe)

Why Is Hospice and Palliative Care the Solution?

- Trained professionals skilled in having: "The Conversation"
- Focused on Quality End of Life Outcomes
- Experts in Pain and Symptom Management

Why Is Hospice and Palliative Care the Solution?

- Grief support for families
- Reduced spending on Futile Treatments
- Dying is a medical condition which deserves same focus as any other medical condition

Hospice and Palliative Care Improve Quality of Life

RCT simultaneous standard cancer care with palliative care co-management from diagnosis vs control of standard cancer care only:

- **Improved QOL** 98 vs. 91.5
- **Reduced depression** 16% vs. 38
- **Reduced 'aggressiveness'** 33% vs. 54%
- ***Improved survival*** 11.6 mos. vs. 8.9 mos.

Late Referrals to Hospice and Palliative Care Are the Norm

- Median length of stay in hospice = 18 days
- 35% of hospice patients receive care for < 1 week before death
- 9.2% >180 days
- Median LOS in hospital before palliative care consultation = 14 days

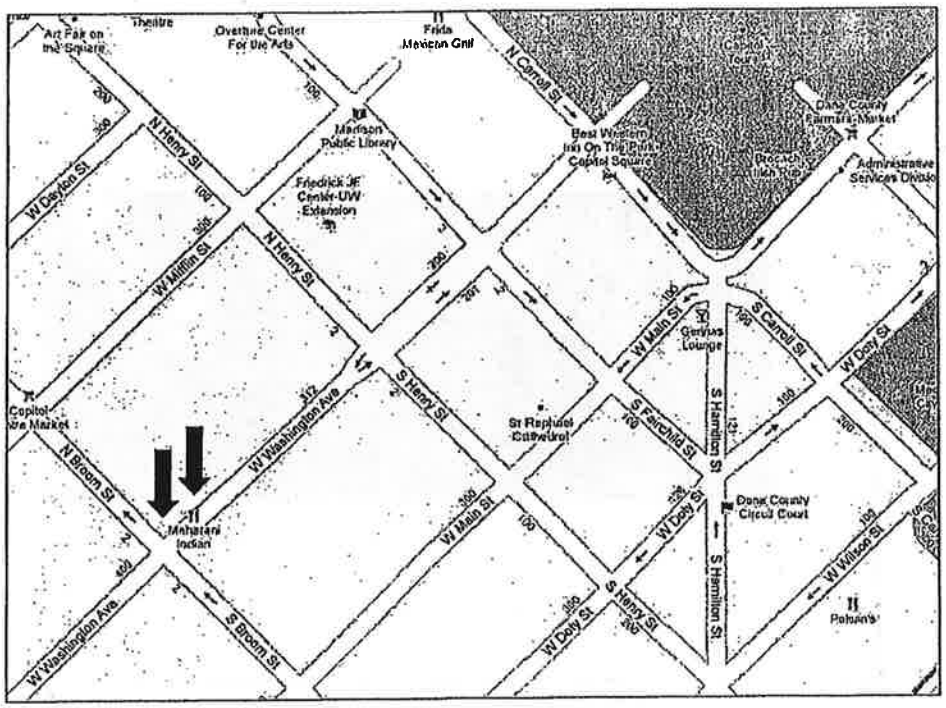
The Hospice Option

- Prognosis of 6 months or less
- Elect comfort versus curative care
- Wherever you call home (residence or long-term care facility)
- Team approach
  - Medical
  - Nursing
  - Social Work
  - Spiritual
  - Grief
  - Caregivers
  - Volunteers

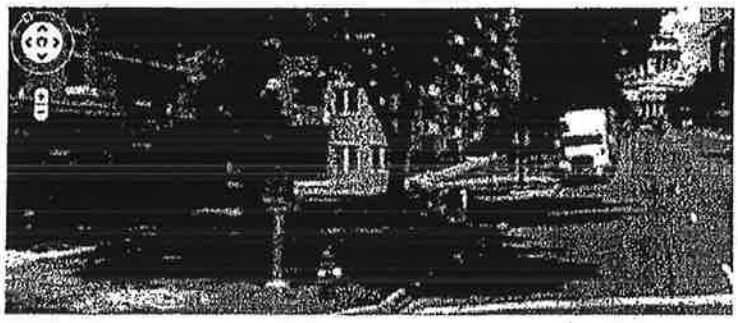
The Hospice Option

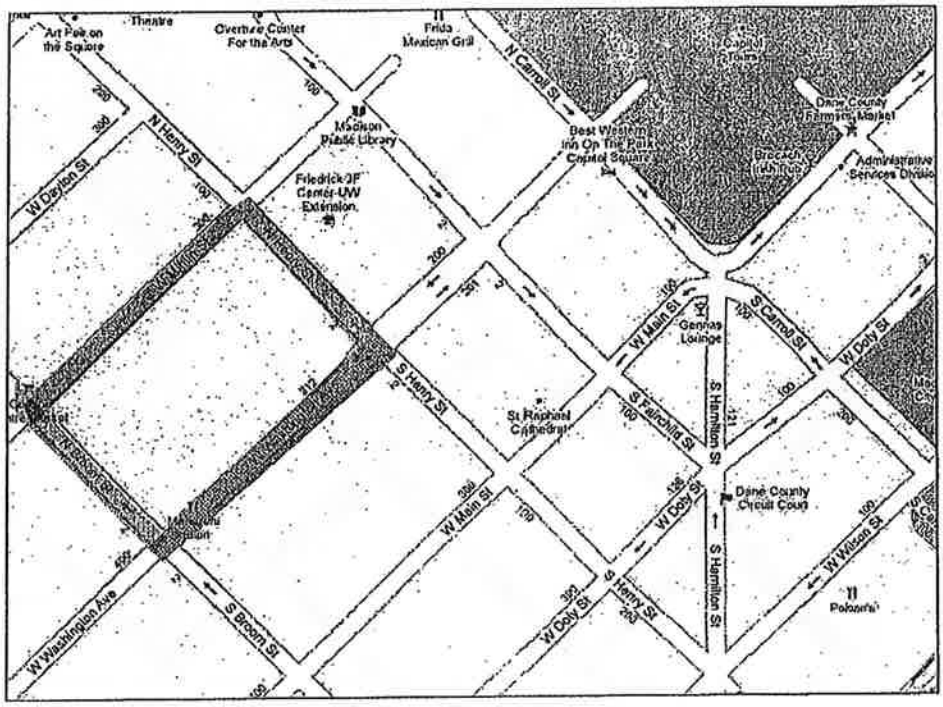
- Covers clinical services, medications, supplies, medical equipment
- Grief support for 13 months after patient death
- Paid for by Medicare and most private insurances

"On the day you were born, you begin to die. Do not waste a single moment more."

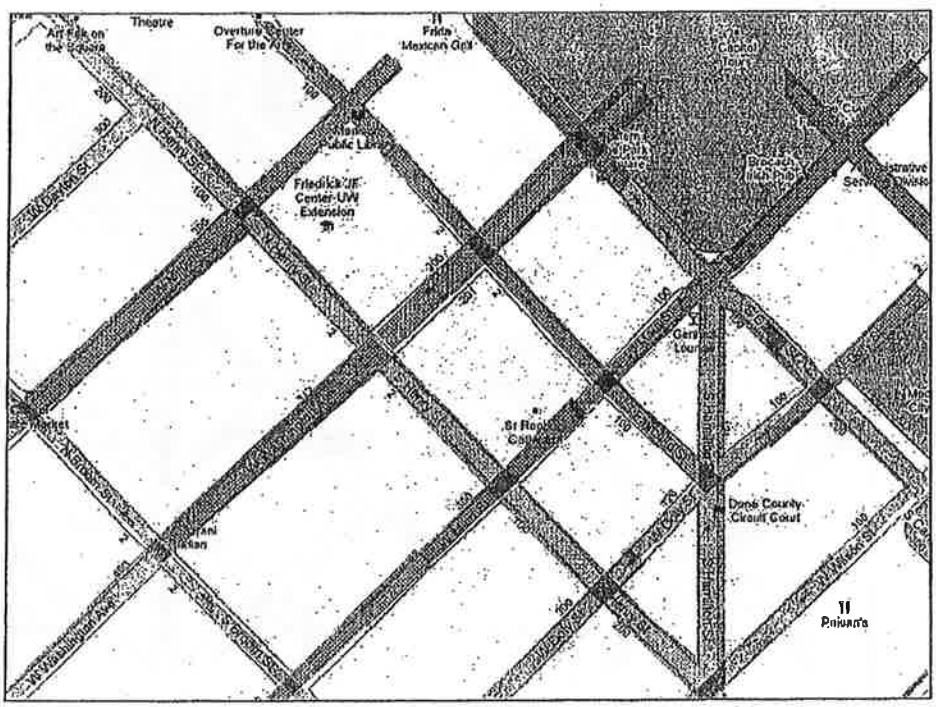


Imagine a japenese tourist approaches and asks: what's the name of this block?

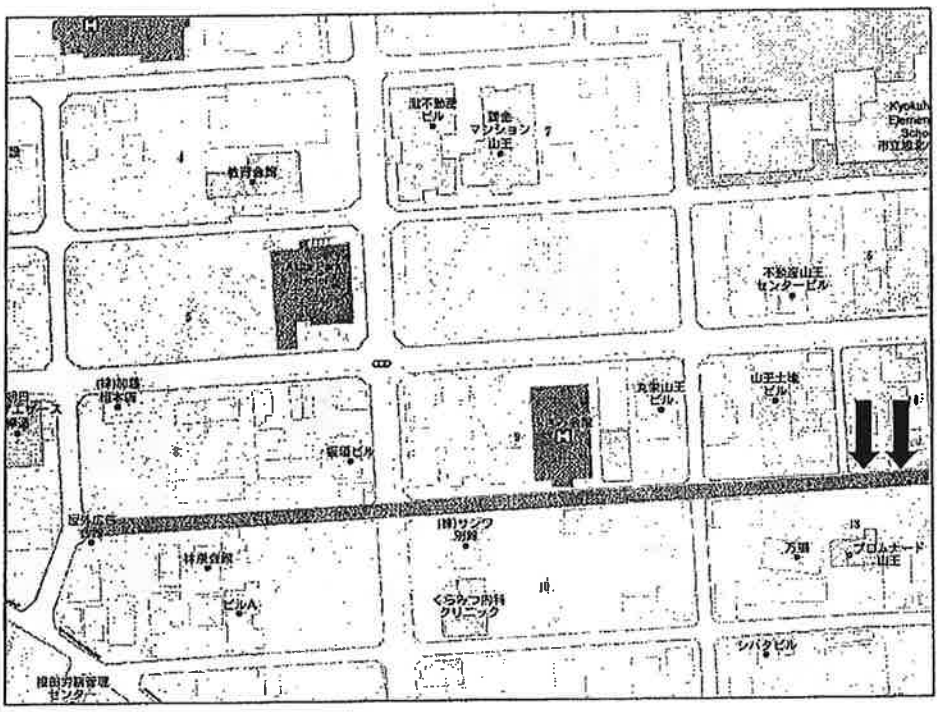




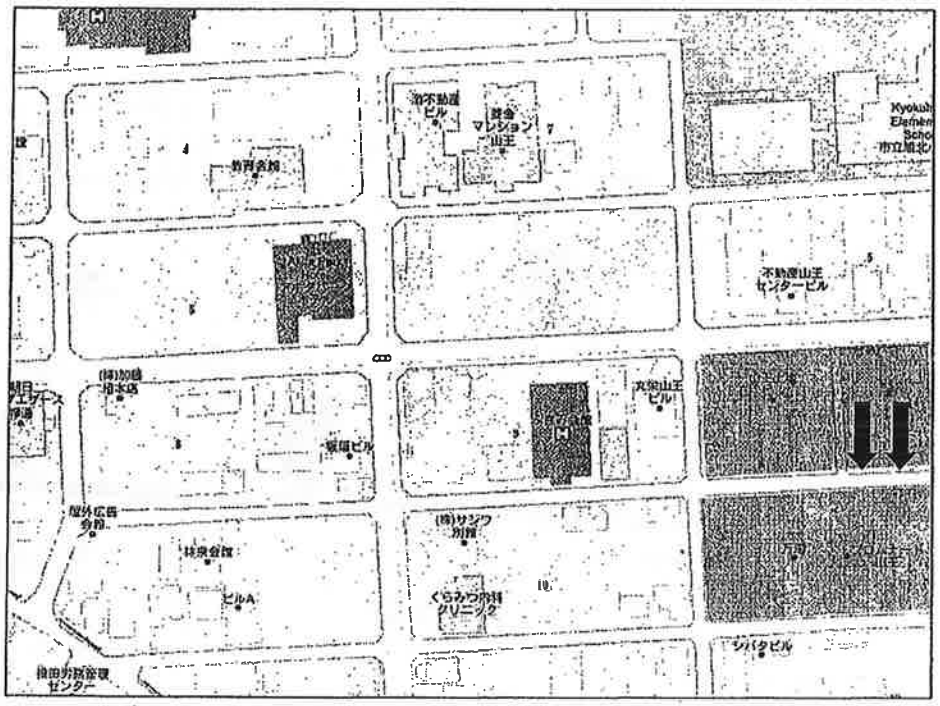
You say the street names,



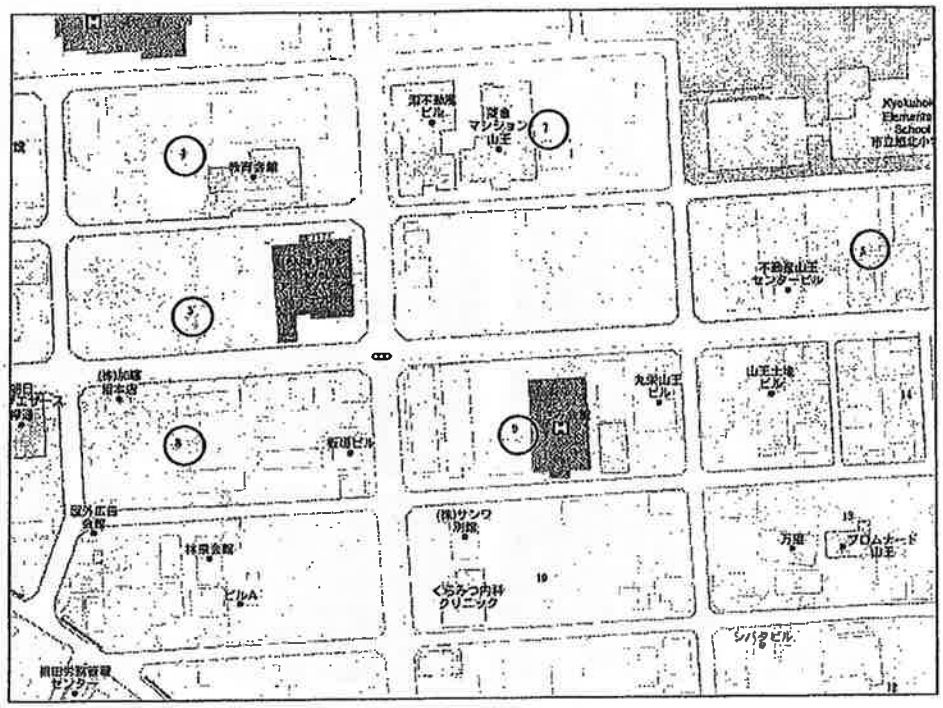
You say the street names,



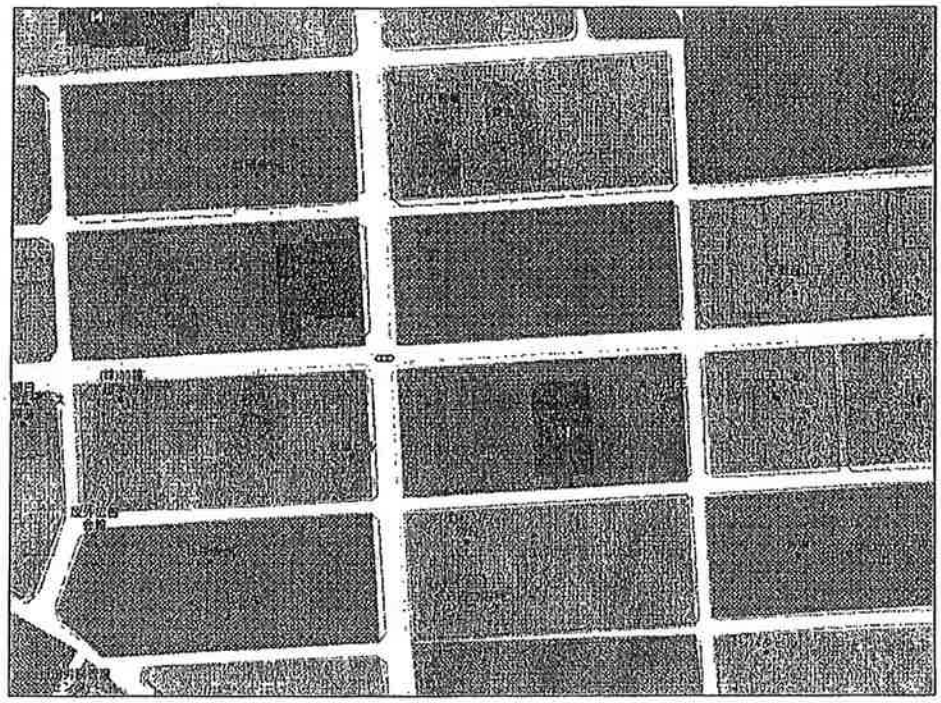
Imagine you're in Japan asking directions, what's the name of this street?



That's block 14 and 13.

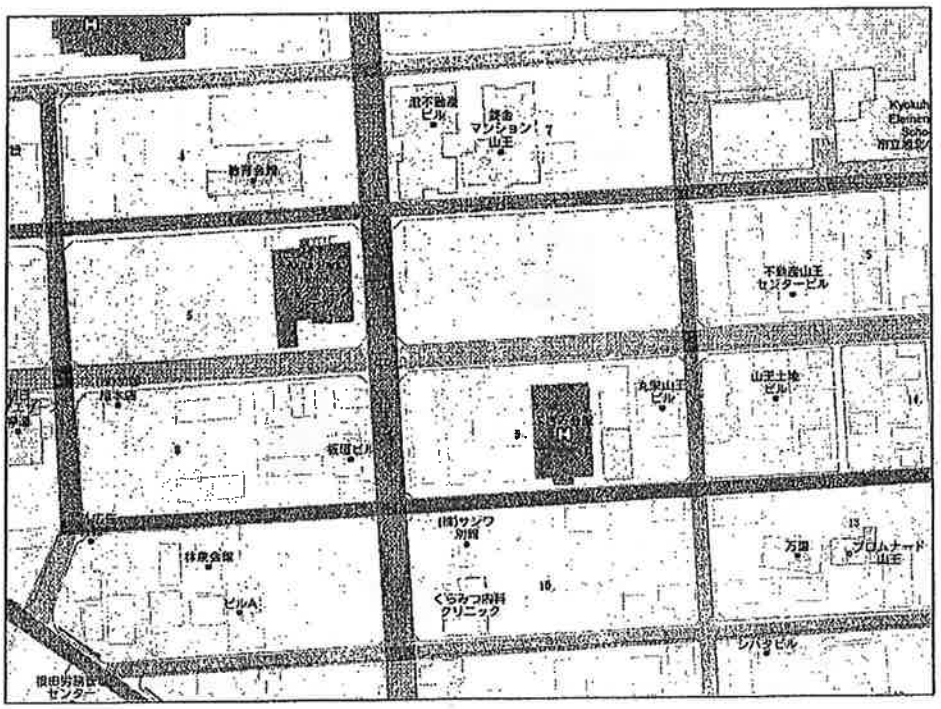


The blocks have names, not the streets.

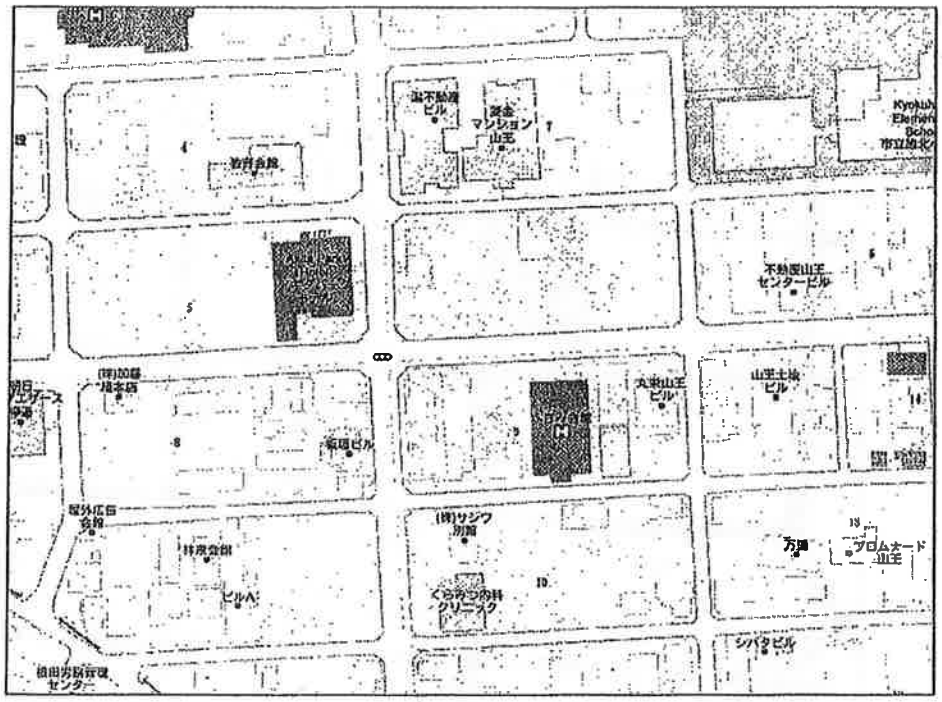


Streets are just the empty space in-between the blocks.

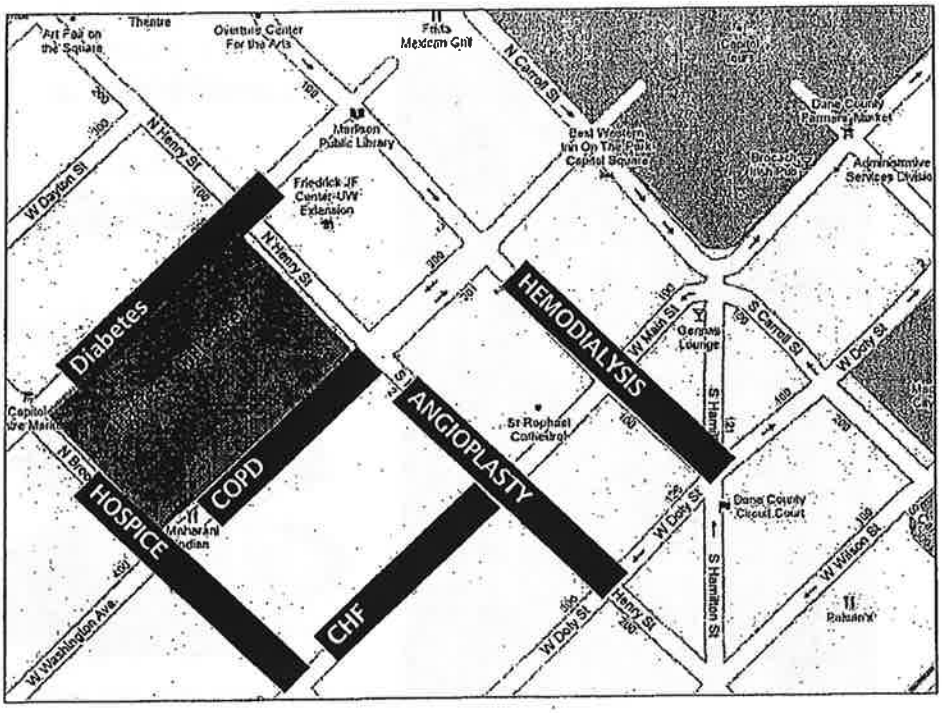
So if there is one way of looking at things, the opposite may also be possible and true.



In America the blocks are the empty space between the streets.



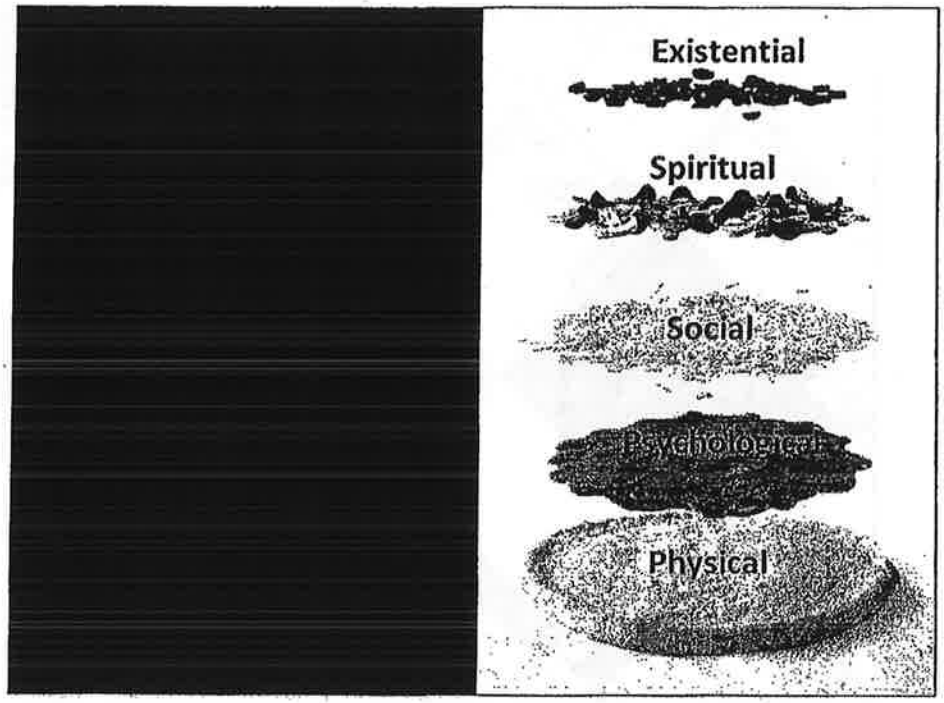
It's gets even more difficult to find your house on the street. They are numbered in the order in which they were built.



This is one of the ways in which I understand how palliative care fits in the American medical system. Our medical system and education system are focused on caring for, and teaching us how to care for, diseases. We learn about the differential diagnosis of Miss Wet Cough, for example. We're caring for diabetes, COPD, and CHF. We learn about the various tests which can be used to evaluate a symptom and how to make a diagnosis and treat a disease. We are in a race for technology and medical advances: hemodialysis, angioplasty, hospice. These are the streets.

But consider the opposite way of looking at this map. In a patient oriented approach, and often this is our focus in palliative care, we exist within the same world, occupy the same streets, but we orient our way around by the blocks: the people who live there; their goals; there hopes; their stories.

This is one way of explaining what Palliative Care is – simply a different way of looking at the same information.



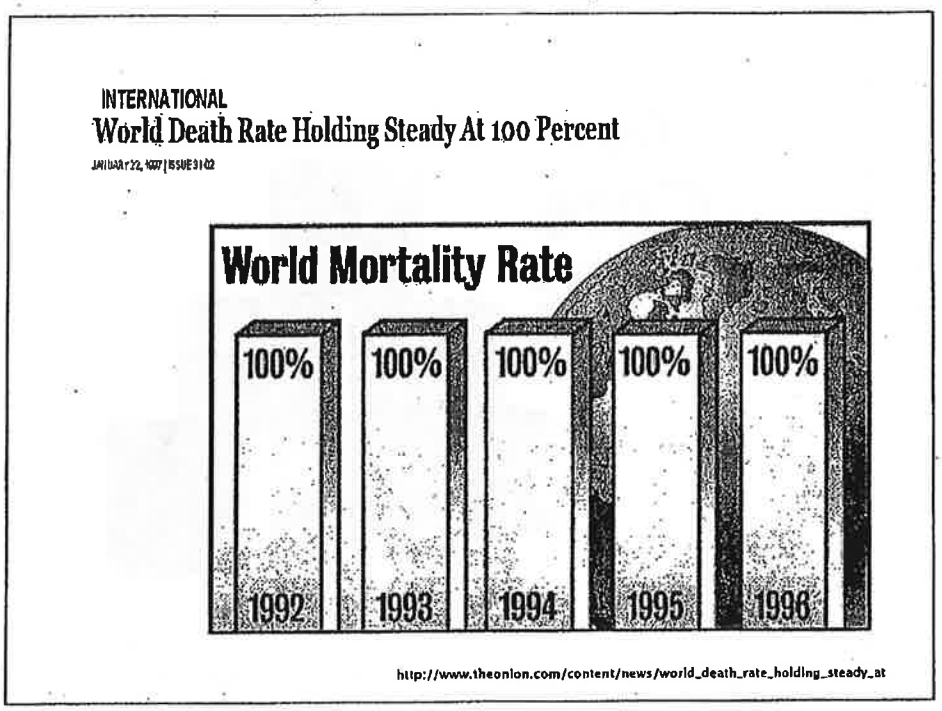
There are varying definitions of palliative care. One that I think encompasses the breadth of this field comes from the IOM, "Improving Palliative Care for Cancer."

Comprehensive multidisciplinary management of patients' needs:

- Physical
- Psychological
- Social
- spiritual
- Existential

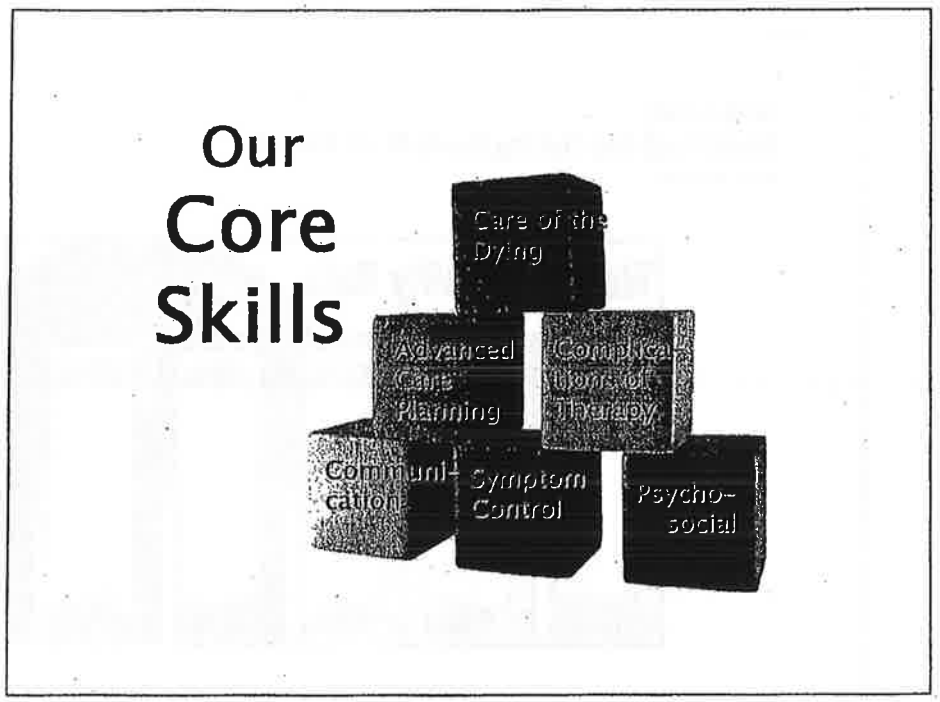
Part of the treatment of any person with a serious or life-threatening medical condition for which a patient-centered approach, pain and symptom control, family involvement and compassionate care are needed.

Palliative care is synonymous with good medical/nursing care, involving all members of the health care team.

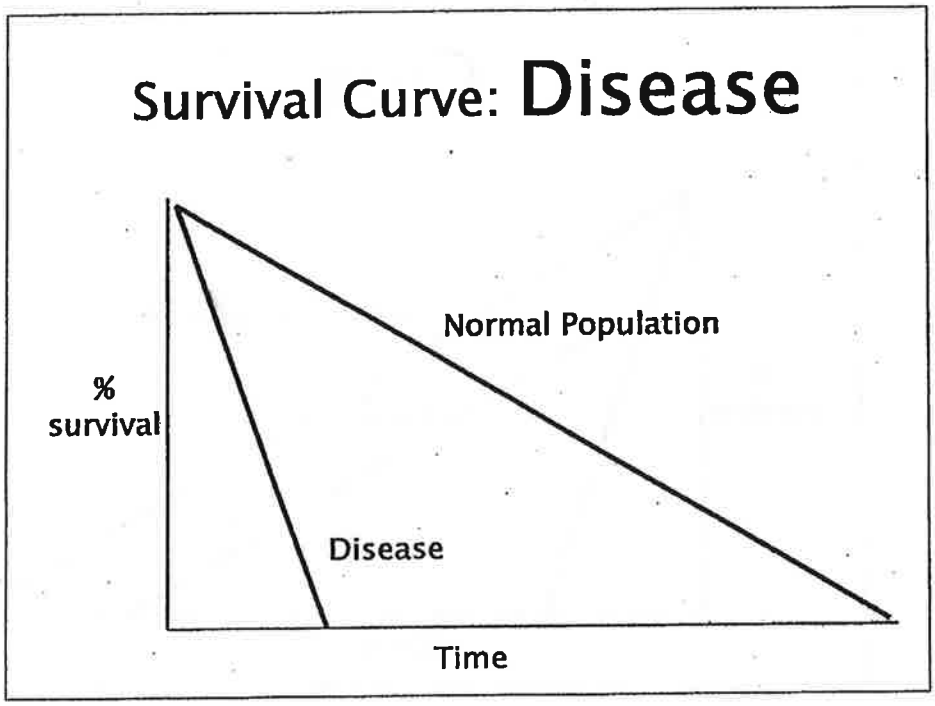


The **scope** of the problem...

"Why should we continue to spend billions of dollars a year on a health care industry whose sole purpose is to prevent death, only to find, once again, that death awaits us all?" Ralph Nader

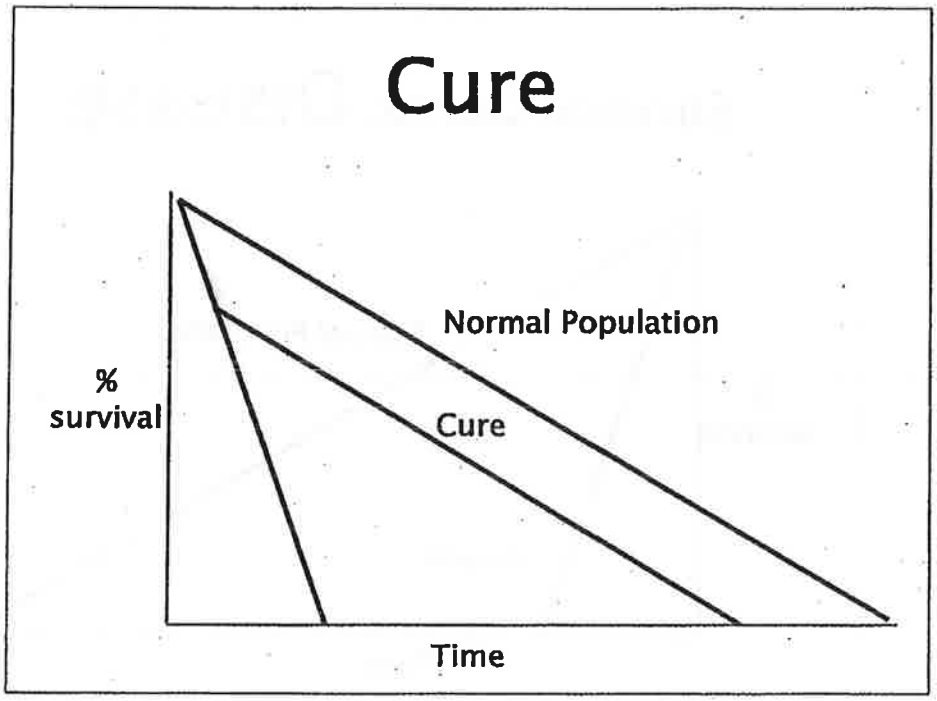


National Cancer Policy Board & Institute of Medicine definitions of the 6 major skill sets that comprise palliative care.

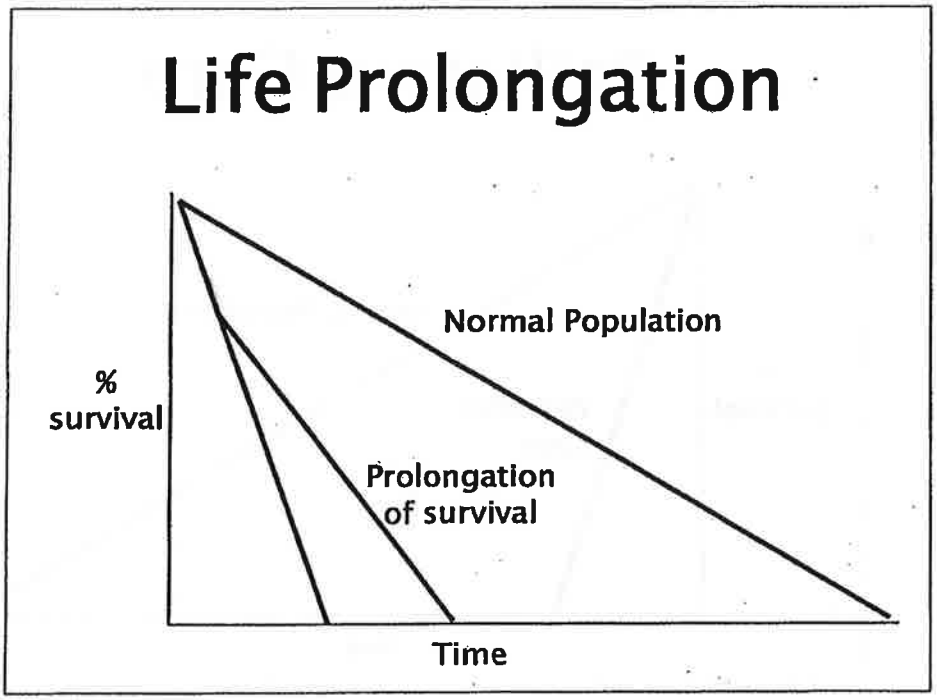


Diseases are curable, not people

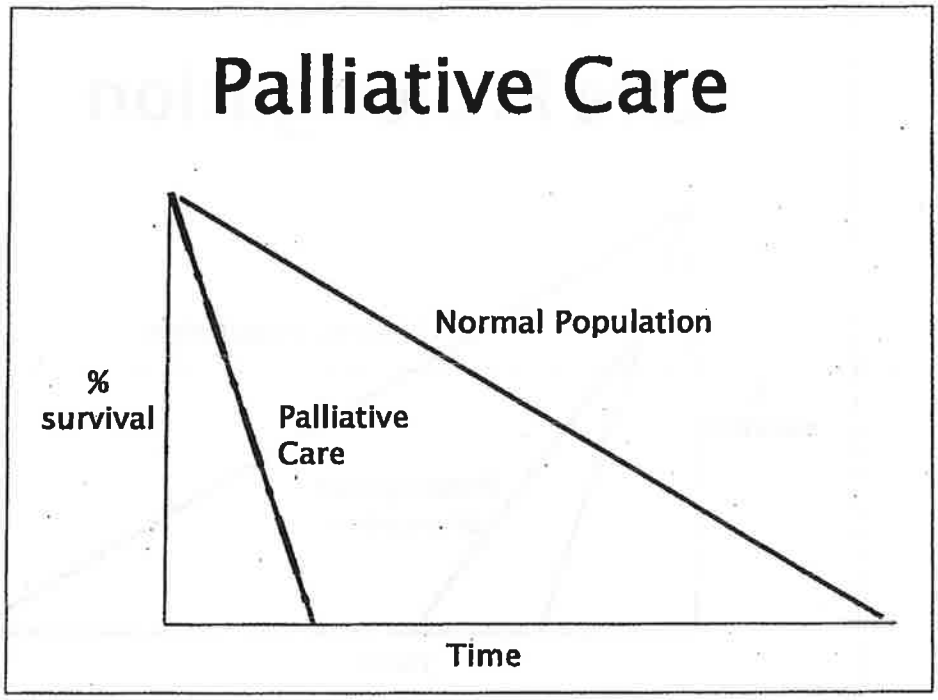
What is a cure? Even in the US 100% die.



Testicular cancer, Early Breast Cancer, Early Colon Cancer, Lymphoma



Prolong survival with treatment. Weeks/months/years.
Metastatic Breast Cancer, Metastatic Colon Cancer, Head and Neck Cancer, Bladder Cancer, Lung Cancer

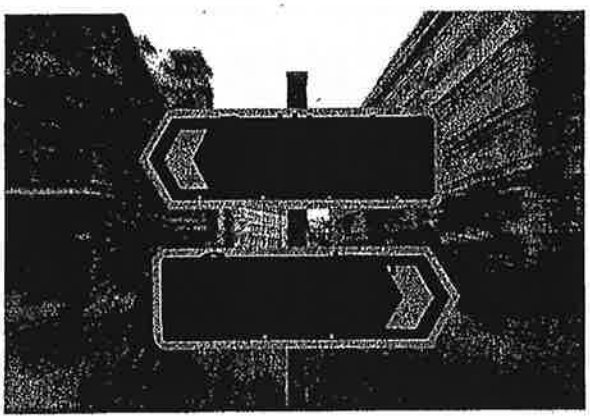


PC has no impact on survival, neither hastens nor postpones the disease trajectory, hopefully just improves QOL and symptom burden during that time.

There is some argument that good symptom management may prolong life.

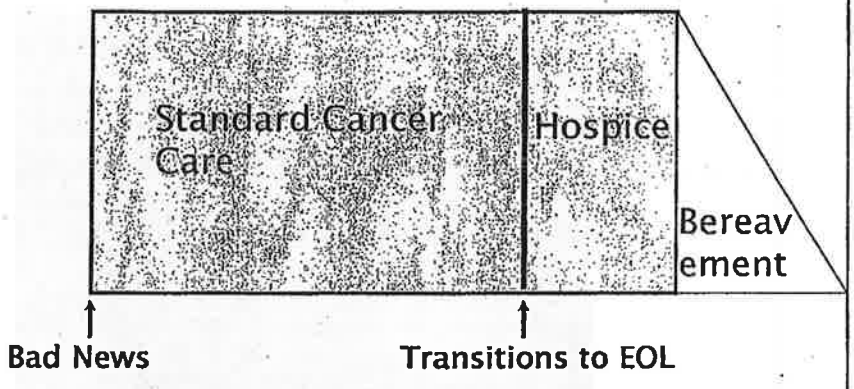
Untreatable: No Available Therapy, Poor Performance Status, Co-morbidities

Intentions of Treatment

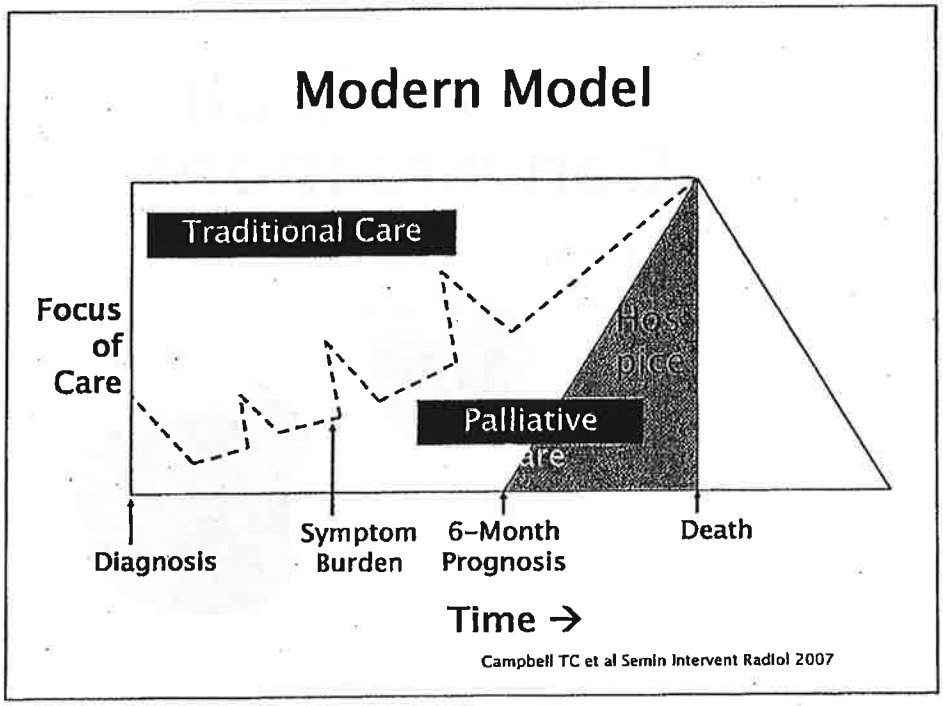


CORE PRINCIPLE is identifying for yourself and the patient the intention of therapy. Life moves quickly when facing bad or difficult news – often it come completely out of nowhere. I think of the story of Agnes, a 93 y/o woman who was in a car accident on her way to the doctor and left with a fractured hip. Shortly after her surgery to correct the painful hip she suffered a devastating stroke. The family had initially agreed to the placement of a feeding tube and tracheostomy but before making a final decision, the nurse recommended the family meet with PCM and the trauma team agreed. After meeting with them, learning more about Agnes' life and values, we had a frank discussion about the likelihood for recovery, expectations for the interventions, and most likely outcomes. The goals became clear that this independent woman, who would never become independent again, would not want to live this way. The goals shifted to comfort care for the dying.

Traditional Model of Cancer Care



*Emanuel LL, Ferris FD, von Gunten CF, Von Roenn JH. EPEC-O: Education in Palliative and End-of-Life Care. Oncology, p. P2-7

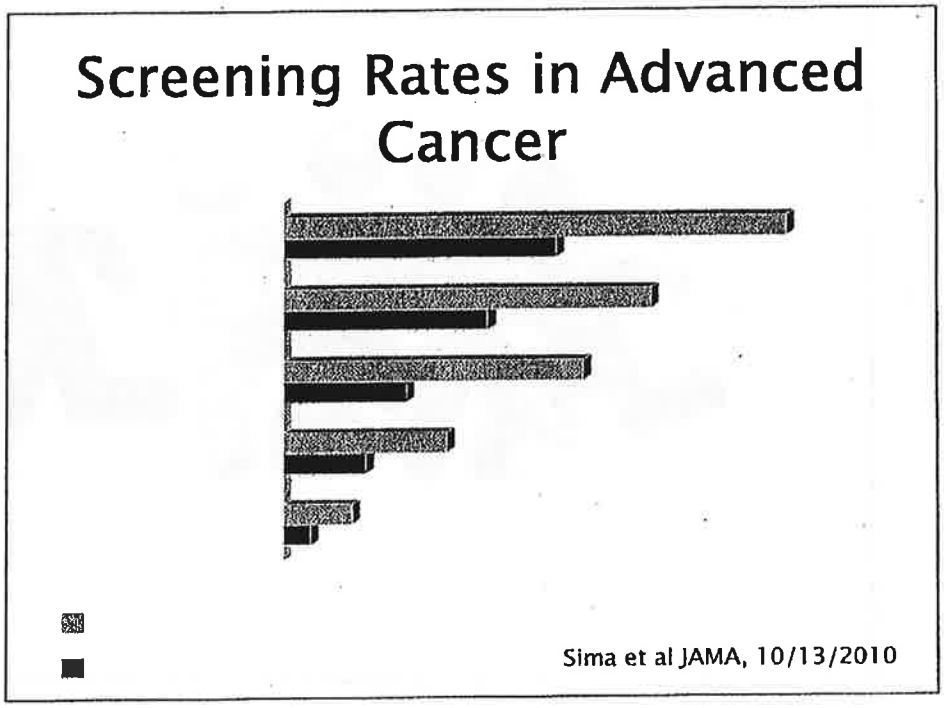


As a patient progresses in their illness the symptom focus of care tends to shift towards a palliative focus (symptom management, preparation for end of life etc). There are frequent exacerbations of symptoms and a rising baseline such that most patients never return to their prior baseline after an exacerbation. At the 6 months mark, by definition, they are a candidate for hospice services. After the patient dies we should offer bereavement services to the family.

Oh No!

Difficult Conversations

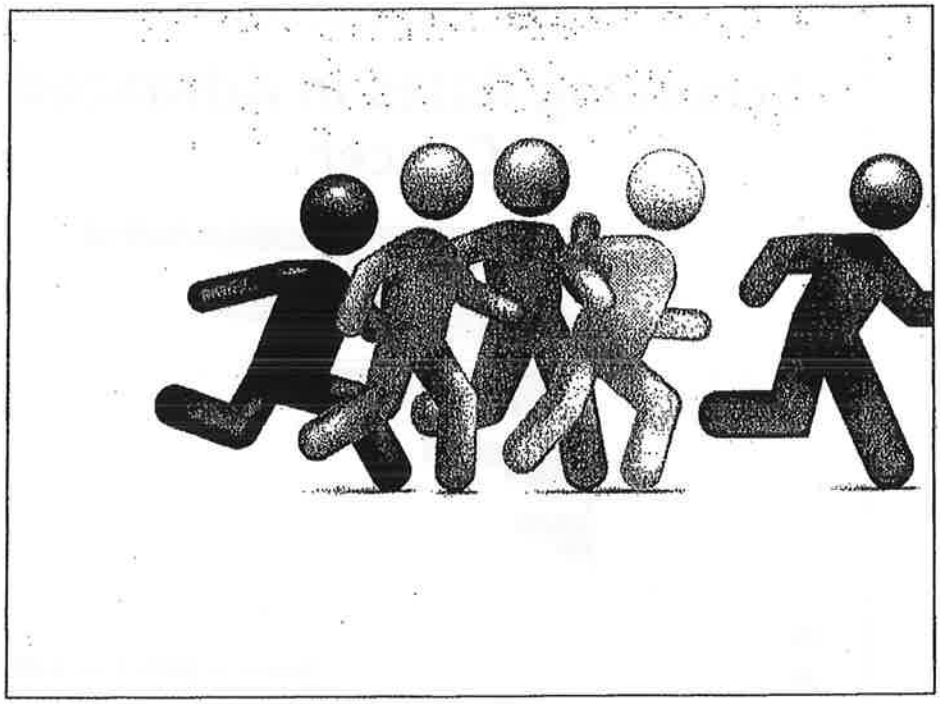
A communication toolkit



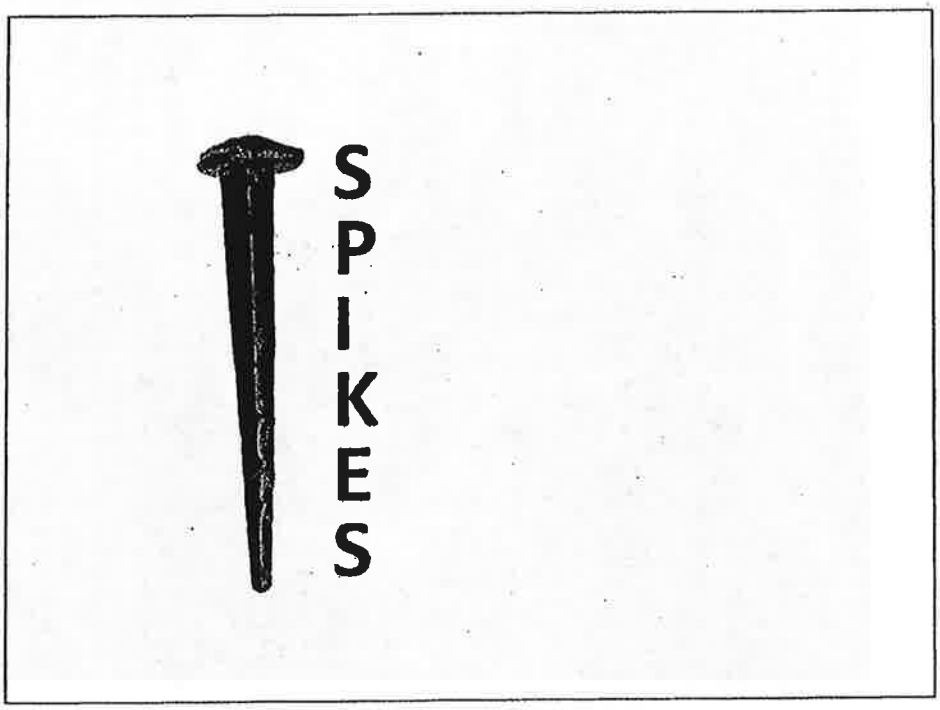
Camelia Sima, Katherine Panageas, Deborah Schrag
Cancer screening among patients with advanced cancer
JAMA, October 13, 2010, volume 304, No. 14

The author is reviewed the S. DER database and assessed 87,736 cases with matched cohort control for the incidence of screening (mammogram, Pap smear, endoscopy, PSA, cholesterol) screening rates in patients with advanced cancer were one half to one third the rates of matched controls. For example, 9% of women with advanced cancer continued to receive mammography, 6% received Pap testing. Among men, 15% underwent PSA testing. 20% of patients with advanced cancer underwent screening cholesterol testing.

This is an opportunity, without any significant controversy, where both money and patient hardship can be spared by stopping routine screening in patients with advanced cancer. If we imagine that screening tests are design to try and reduce the morbidity and mortality from preventable diseases, they are unnecessary in patients for whom we already know the likely cause of death: Cancer.



Said another way, we are all heading towards the end of our life from the moment we are born. If competing causes for mortality are perceived as racing for the finish line, if we already know the winner, we don't need to continue looking to see who is in second, third, or fourth place.


SPIKES

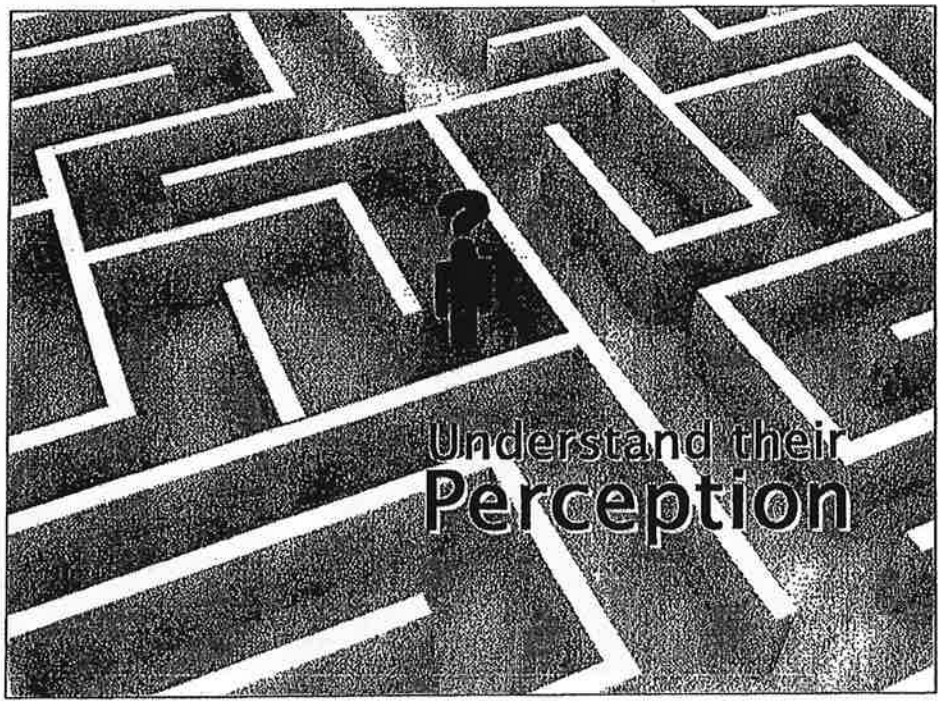
This is a bit of a performance, make sure you know who the audience is, that they are all in attendance, that everyone – including yourself – has a seat.

The physician or team should discuss their objectives for the conversation in advance, and arrange for privacy.

Make sure everyone who should be there has a seat at the table (involve significant friends and family members).

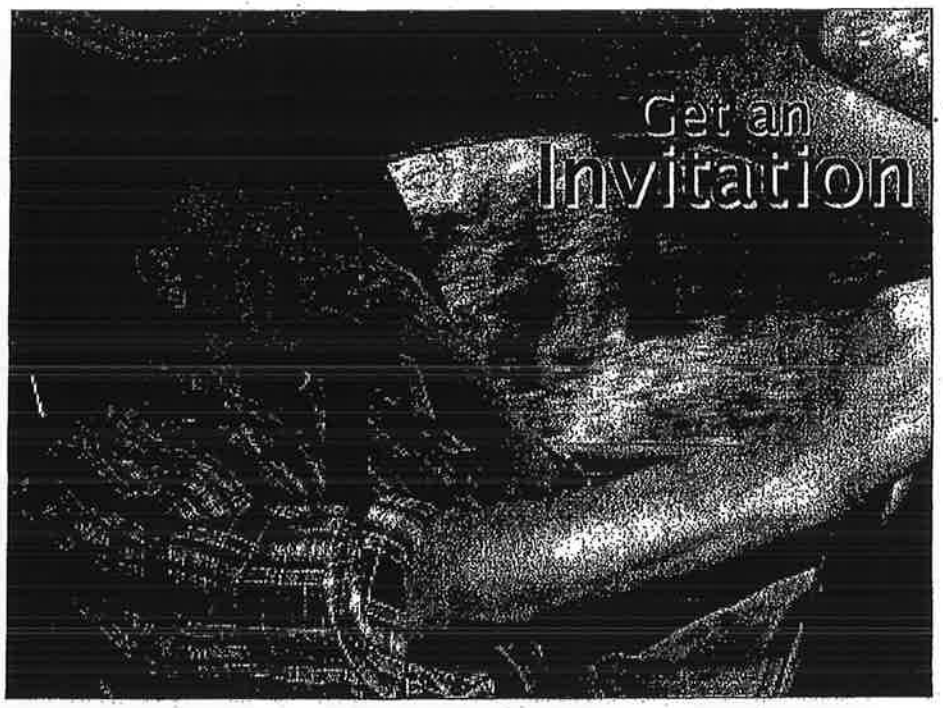
Sit down.

Try to reduce potential interruptions.



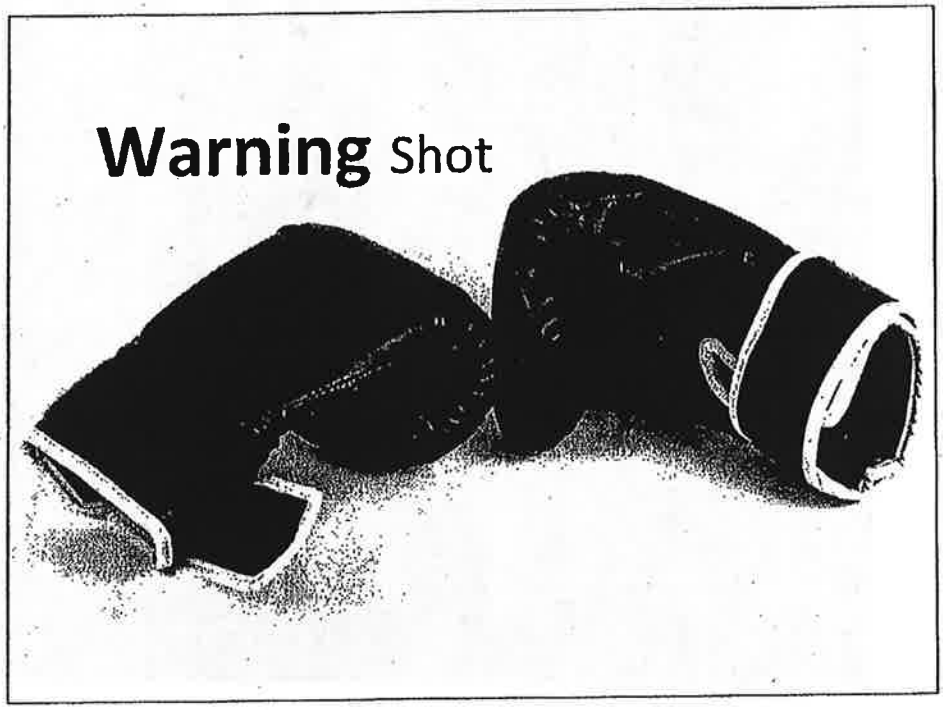
How can you direct the patient if you don't know where they are in their understanding? The answer to "right or left" depends on where they are standing. Seek first to understand, then guide.

The most important assessment to gain is the patients understanding of their condition. "I want to make sure you and I are on the same page, can you tell me what you understand about what is happening now?" or "What is your understanding of why we did the CT scan?" The few minutes spent assessing their understanding gains important information about their perceptions and misconceptions as well as any unrealistic expectations. Often, by seeking first to understand, one finds the patient already knows, or suspects, most of the new information. Or, one may discover they have a great deal of ground to cover but both conversations are more easily managed by knowing upfront what needs to be accomplished.

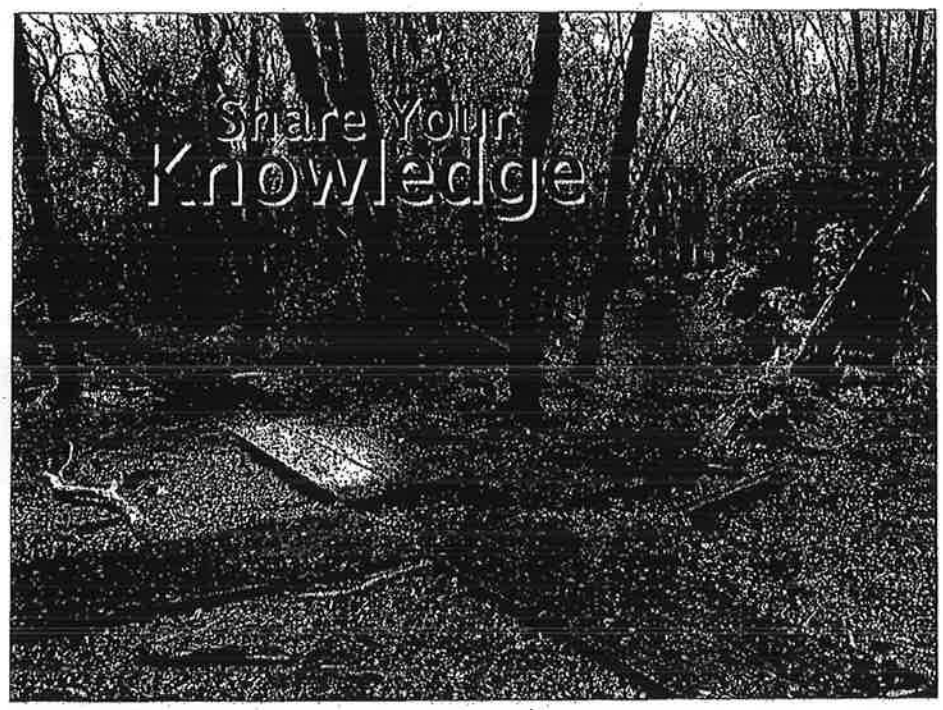


"Is this an okay time to go over the results of your CT scan?" Or are you driving down the interstate at 65 MPH.

The invitation may be obvious if the patient has returned to clinic for CT results or more subtle: "How much information do you want about the test results when they come back? Is there anyone else you want present if we have to discuss bad news?" While most patients desire complete disclosure of information, some patients do not. The invitation respects the patient's autonomy by ensuring the timing is convenient for them to have a serious conversations.



A primary difference between bad news delivered poorly and well is the aftermath.
The gloves are off and you cannot soften the blow, this is bad news.
But you can catch the patient when they fall.

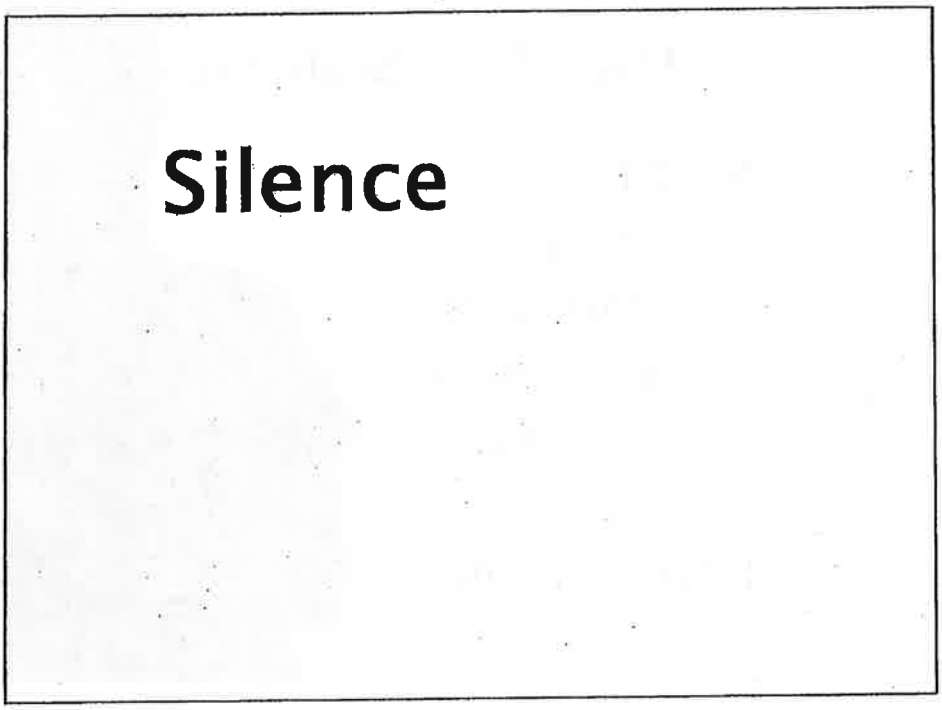


Our patient is a fork in the road of life. They are scared, wondering which path life is taking them. Do they have a choice?

By providing test results and recommendations, we intend to give the patient knowledge about their life and health. Knowledge is a higher cognitive order than information because knowledge means they are able to understand the information, incorporate into their mental framework, and then use the information to make decisions and act. The first step in helping patients be ready to receive information is by warning them bad news is coming, a "warning shot."

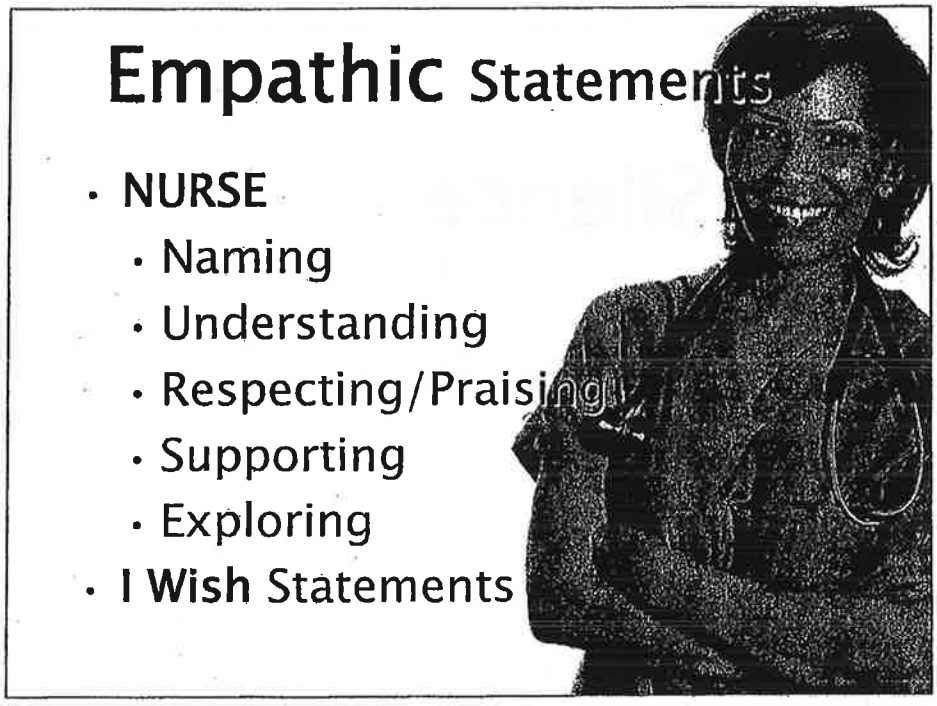
Strategically, there are several verbal skills to use to continue to build a relationship with the patient even when bad news is being delivered.

- Avoid the use of medical jargon (see common translations in table)
- Give a maximum of three pieces of information before checking in with the patient for understanding. "The CT shows the cancer has spread to the liver. This means the cancer is not curable though we can certainly treat both your symptoms and the cancer with medicines. Do you understand?"
- Emphasize what can be done: "while we cannot treat your cancer directly with chemotherapy or radiation, we can be very aggressive in our attempts to control your pain and shortness of breath. You need not suffer."
- Avoid negative phrasing: "there is nothing more we can do."



That was 5 seconds. Feels like a long time. Patients rarely make us wait even that long.

After breaking bad news, allow the patient to have the next word even if seconds or minutes pass. This gives them space and time to consider the information and reflect and react to it. I imagine this is like a tennis match, you have just hit a ball to the patient and you must wait until they hit it back.

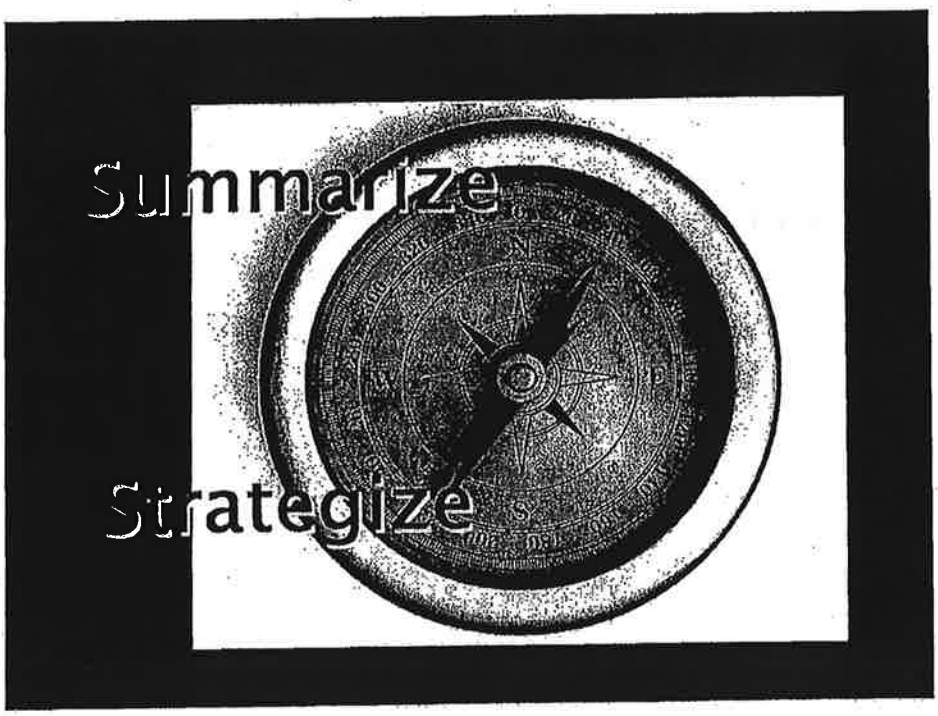


Imagine you have reached the end of the pier. No boat. No options. No return. The seas are rough.

Observe the patient's reaction and note any emotions you see. Simply try and identify or name what you think they are feeling: "You must be sad."

Explore the emotion to give the patient permission to express themselves and avoid presuming their emotion is due to the news itself. "You seem angry, can you tell me about it?"

Allow the emotion to pass before moving on to the next steps. If one rushes ahead before the patient is emotionally ready, they frequently do not process or remember the next pieces of information. In effect, you save time at a later appointment by not having to repeat information.



When patients are ready to proceed, move forward into your diagnostic and therapeutic recommendations. Continue to limit the amount of information into manageable pieces and check for understanding. Emphasize your ongoing relationship with the patient to try and allay fears of abandonment and further loss. Finally, set a time to meet again.

Historical Legal

- In re Quinlan (1976)
  - New Jersey Supreme Court
  - Young woman; persistent vegetative state
  - Genesis of living wills

In re Quinlan, 355 A.2d 647 (N.J. 1976)

Historical Legal

- Cruzan v. Director, Missouri Department of Health (1990)
  - U.S. Supreme Court
  - Young woman; persistent vegetative state
  - Constitution grants the right to refuse live-saving nutrition and hydration (based on liberty interests in 14th Amendment)
  - Balanced against 'relevant state interests'
  - Insufficient showing to terminate support

Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990)

U.S. Supreme Court upheld Missouri law requiring 'clear and convincing' evidence of the incompetent's wishes as to withdrawal of treatment.

Relevant state interests that are balanced against the Liberty Interest of the 14th Amendment include:
1) Safeguarding the personal element of an individual's choice between life and death;
2) Protecting individuals from potential abuses by self-interested family members acting as surrogate decision-makers;
3) Considering that a judicial proceeding regarding an incompetent's wishes might not be adversarial and might lack the guarantee of accurate fact-finding;
4) Declining to make judgments about a particular individual's quality of life and instead simply asserting an unqualified interest in the preservation of human life.

Historical Legal

- Wisconsin Legislative Response:
  - Chapter 154 - Advanced Directives (Living Wills)
  - Chapter 155 - Power of Attorney For Health Care
  - Chapter 154, Subchapter 3 - Do-Not-Resuscitate Orders

Historical Legal

- In re Guardianship of L.W. (1992)
  - Ward was in persistent vegetative state
  - Ward was never capable of expressing his medical wishes
  - General rule: Surrogate must act in ward's 'best interests'
  - Presumption: preserving life is in ward's best interests
  - Presumption may be rebutted based on certain factors

In re Guardianship of L.W., 167 Wis. 2d 53, 482 N.W.2d 60 (1992).

The guardian argued for a 'substituted judgment' test, considering the ward's past values, wishes and belief; the state argued in favor of a 'clear and convincing standard' of the ward's desires. The Court rejected both.

The Court imposed an objective 'best interests' standard, creating a presumption in favor of continued medical treatment. This presumption can be rebutted by examining such factors as: the degree of humiliation, dependence, and loss of dignity continued medical treatment imposes on the patient; the patient's life expectancy and prognosis for recovery; the patient's various treatment options; and the risks, side effects and benefits of these options.

Historical Legal

- In the Matter of the Guardianship and Protective Placement of Edna M.F.
  - Ward was not in a persistent vegetative state
  - Ward had not clearly expressed her medical wishes
  - Presumption: preserving life is in ward's best interests
  - Presumption may not be rebutted absent the ward's 'clear statement' of wishes

Historical Legal

GUARDIANSHIP OF LW

General Rule: Must act in patient's '*Best Interests*'

Presumption: Preserving life (by continuing treatment) is In patient's best interests

Factors In Rebutting Presumption:

The degree of humiliation, dependence, and loss of dignity; life expectancy and prognosis for recovery; various treatment options; and the risks, side effects and benefits of these options

GUARDIANSHIP AND PROTECTIVE PLACEMENT OF EDNA MF

General Rule: Must Act In Patient's 'Best Interests'

Presumption: Preserving Life (By Continuing Treatment) Is In Patient's Best Interests

Non-Rebuttable Presumption:

As a matter of law, medical treatment cannot be withdrawn

Why: Because of the state's interest in preserving life, and because of the irreversible nature of the decision to withhold medical treatment

SEE: DISCUSSION IN BOTH LW AND EDNA MF

General Rule: Follow patient's wishes; either under the Best Interests Rules (i.e. a patient's clearly expressed wishes are ipso facto in his/her 'best interest', or under the Substituted Judgment Rule

Exception: Wis. Stat. §154.03(1), if withdrawing medical treatment would cause pain or discomfort that cannot be alleviated through other medical means

SEE: DISCUSSION IN BOTH LW AND EDNA MF

General Rule: Follow patient's wishes; either under the Best Interests Rules (i.e. a patient's clearly expressed wishes are ipso facto in his/her 'best interest', or under the Substituted Judgment Rule

Exception: Wis. Stat. §154.03(1), if withdrawing medical treatment would cause pain or discomfort that cannot be alleviated through other medical means

Historical Legal

- Summary: Unless a patient is in a persistent vegetative statement, the patient must 'clearly state' his/her desires regarding medical treatment, or treatment must be continued (i.e. continued medical treatment is ipso facto in the patient's 'best interests').

Historical Legal

- Exception to 'clear statement' of wishes: 154.03(1), 155.20(4):
  - If withholding or withdrawing medical treatment will cause the patient pain or reduce the patient's comfort, and the pain or discomfort cannot be alleviated through relief measures, medical treatment must be continued, regardless of patient's stated wishes.

'Clearly Stating' Wishes

- Chapter 154 – Advance Directives
  - Applies to 'terminal conditions'
  - Applies to 'persistent vegetative state'
  - Very limited utility; do not use statutory form
  - Summary: Chapter 154 is a safe harbor, but it is certainly not exclusive

Wis Stat 154.01(8) defines 'terminal condition' to be an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

Wis. Stat. 154.01(5m) defines 'persistent vegetative state" to be a condition that reasonable medical judgment finds constitutes complete and irreversible loss of all of 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.

'Clearly Stating' Wishes

- Use Chapter 155: Power of Attorney For Health Care
- Much less limiting than Chapter 154
- Use statutory form HCPOA
- Supplement HCPOA with Addendum that serves as a Living Will
- See Appendix for Samples

For statutory health care POA form, with addendum, see:
http://www.wisbar.org/AM/Template.cfm?Section=elder&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=99092

'Clearly Stating' Wishes

- Five Wishes form:
  - Wish #1: Naming surrogate
  - Wish #2: Medical treatment choices
  - Wish #3: How comfortable I want to be
  - Wish #4: How I want people to treat me
  - Wish #5: What I want my loved ones to know
  - See Appendix for Sample Five Wishes Form

Five Wishes online: https://fivewishesonline.agingwithdignity.org/

'Clearly Stating' Wishes

- The HCPOA must be:
  - In writing;
  - Dated and signed by the principal or by an individual who has attained 18 at the express direction and in the presence of the principal;
  - Signed In the presence of 2 qualified witnesses; and
  - Is voluntary executed.

To be a qualified witness, he/she must be at least 18 years of age, and not: (1) an individual related to the principal by blood, marriage or adoption; or (2) An individual having knowledge that he or she is entitled to or has a claim on any portion of the principal's estate; or (3) an individual who is directly financially responsible for the principal's health care; or (4) an individual who is a health care provider serving the principal at the time of execution; an employee, other than a chaplain or a social worker, of the health care provider; or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the principal is a patient; or (5) an individual who is the principal's health care agent.

'Clearly Stating' Wishes

- The HCPOA takes effect when the principal is 'incapacitated'
  - The determination if 'incapacity' requires written certification by two physicians or a physician and a psychologist who have personally examined the principal
  - The certification must be appended to the HCPOA

Wis. Stat. 155.01(8) defines 'incapacity' to be the inability to receive and 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.

'Clearly Stating' Wishes

- Do-Not-Resuscitate Orders
  - Issued by a patient's attending physician
  - Patient must be a 'qualified patient'
  - The patient is fitted with a bracelet bearing the inscription: "Do Not Resuscitate"

Wis. Stat. 154.19 (1) provides that a DNR order may only be issued if all of the following apply:
1)The patient is a 'Qualified Patient';
2)The patient requests the order (or, if the patient is incapacitated, the patient's guardian or health care agent requests the order);
3)The patient consent to the order after receiving certain mandated information (or, if the patient is incapacitated, then either the guardian or the health care agent consents after receiving the mandated information);
4)The order is in writing;
5)The patient signs the order (or, if the patient is incapacitated, the requesting guardian or health care agent signs); and
6)The physician does not know the patient is pregnant.

Wis. Stat. 154.17(4) defines a Qualified Patient as a person who has attained 18 and to whom any of the following conditions apply:
1)The patient has a terminal condition.
2)The patient has a medical condition such that, were the person to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful in restoring cardiac or respiratory function or the person would experience repeated cardiac or pulmonary failure within a short period before death occurs; or
3)The person has a medical condition such that, were the person to suffer cardiac or pulmonary failure, resuscitation of that person would cause significant physical pain or harm that would outweigh the possibility that resuscitation would successfully restore cardiac or respiratory function for an indefinite period of time.

"To live in this world you must be able to do three things:

To love what is mortal;

To hold it against your bones knowing your own life depends on it;

And when the time comes to let it go, to let it go."

--Mary Oliver

- **Toby Campbell, MD**
  Assistant Professor Medical Oncology and Palliative Medicine UW School of Medicine and Public Health
- **Denise Gloede, RN, BSN, CHPN**
  Vice President of Access Agrace HospiceCare
- **Richard J. Langer**
  Partner, Michael Best & Friedrich, LLP

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 31st day of August, 2010.

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, **RICHARD J. LANGER**, 1502 Windfield Way, Middleton, Wisconsin 53562, born June 10, 1944, 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 my wife, **AUDREY A. LANGER**, 1502 Windfield Way, Middleton, Wisconsin 53562, (608) 831-7344, to be my health care agent for the purpose of making health care decisions on my behalf. If she is ever unable or unwilling to do so, I hereby designate my daughter, **KATHLEEN M. LANGER**, 10138 South Statesman Place, South Jordan, Utah 84095, (801) 446-7212, to be my alternate health care agent for the purpose of making health care decisions on my behalf. If she is ever unable or unwilling to do so, I hereby designate my son, **MICHAEL R. LANGER**, 625 Charles Lane, Madison, Wisconsin 53711, (503) 756-2171, to be my second 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 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 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 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 her health care decision on what 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.

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. Photocopies of this Power of Attorney for Health Care Document may be made and such photocopies shall have the same force and effect as the original (Wis. Stat. § 155.70(6)).
2. If my health care agent is not available to make health care decisions in accordance with the above, I hereby request my physician and those participating in making health care decisions for me in the event of my incapacity to follow the instructions and honor my desires as expressed herein.
3. If I have signed an Addendum to the Power of Attorney for Health Care, and this Addendum has not been revoked, I direct my health care agent to follow my instructions as contained in that Addendum.
4. _____

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 Richard J. Langer Date 8-31-10

(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 to be of sound mind and at least 18 years of age. I believe that his 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 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 No. 1

(Print) Name Sheila Bobby Stevens Date 8/31/2010

Address 1113 Woodbridge Trail, Waunakee, WI 53597

Signature [signature]

Witness No. 2

(Print) Name Barbara J. Hermann Date 8-31-2010

Address 2801 Richardson St. Fitchburg WI 53711

Signature Barbara J. Hermann

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that **RICHARD J. LANGER** has designated me to be his health care agent or alternate health care agent if he is ever found to have incapacity and unable to make health care decisions for himself. **RICHARD J. LANGER** has discussed his desires regarding health care decisions with me.

Agent's Signature Audrey A. Langer

AUDREY A. LANGER

Address: 1502 Windfield Way, Middleton, Wisconsin 53562

Alternate's Signature Kath Langer

KATHLEEN M. LANGER

Address: 10138 South Statesman Place, South Jordan, Utah 84095

Alternate's Signature [signature]

MICHAEL R. LANGER

Address: 625 Charles Lane, Madison, Wisconsin 53711

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 8-31-10

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ADDENDUM TO THE POWER OF ATTORNEY FOR HEALTH CARE

If I am in a Terminal Condition, a Persistent Vegetative State, or have Advanced Dementia or Other Similar Mental Incapacity, I direct my health care power of attorney to carry out my wishes as provided below. I agree and/or disagree with the following:

Agree	Disagree	
☑	☐	Do not use feeding tubes, including stomach tubes, nasogastric tubes or intravenous feedings.
☑	☐	Do not perform any surgical procedures.
☑	☐	Do not use antibiotics.
☑	☐	Do not use vaccine for vaccine preventable disease.
☑	☐	Do not do any testing which may cause me any distress.
☑	☐	Do not do any radiation or chemotherapy.
☑	☐	Do not do any resuscitation or advanced life support. This includes machines to help breathing or medications to maintain the heart and blood pressure.
☑	☐	Do not do kidney dialysis, either peritoneal or hemodialysis.
☑	☐	Notwithstanding the above general directives, such procedures and medications may be used to increase my comfort or reduce my pain, if such comfort or pain cannot be otherwise appropriately managed through medication for pain. Err on the side of over-medication rather than under-medication for comfort and pain, even if taking such may result in my death. For me, the goal of comfort and pain management is total relief of pain regardless of the risks.
☑	☐	Be an active advocate as my health care power of attorney. Do not simply give in to decisions that physicians made. Ask questions and understand proposals, challenge assumptions and be prepared to say no to care which I would not want and to demand care that I would want.

Signed _____
RICHARD J. LANGER

Date 8-31-10

Witness _____

Witness _____

A-6

As used in this Addendum, I intend that the following terms have the following meanings:

Terminal Condition:	An incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.
Persistent Vegetative State:	A condition that reasonable medical judgment finds constitutes complete and irreversible loss of all of the functions of the cerebral cortex and results in a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue.
Advanced Dementia or Other Similar Mental Incapacity:	A brain illness or brain injury, including traumatic head injury, brain disease which is vascular in origin, Alzheimer's disease, and other brain illnesses or dementia caused by infirmities of aging, which is permanent and irreversible and which causes substantial diminishment in the quality of my life as evidenced by 1) an inability to recognize my family and friends, 2) an inability to communicate meaningfully to my family and friends, and 3) an inability to provide for my own care and custody.

HIPAA RELEASE AND AUTHORIZATION

I hereby designate my wife, **AUDREY A. LANGER**, to serve as my Personal Representative under HIPAA and to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable or otherwise protected health information or other medical records. If my wife is unable or unwilling to serve as my Personal Representative, I hereby designate my daughter, **KATHLEEN M. LANGER**, currently of South Jordan, Utah, to serve as my successor Personal Representative. If my daughter is unable or unwilling to serve as my Personal Representative, I hereby designate my son, **MICHAEL R. LANGER**, currently of Madison, Wisconsin, to serve as my successor personal Representative. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. parts 160 and 164 ("The Privacy Rule"), the Confidentiality of Patient Health Care Records, as governed by Wis. Stat. 146.82, and all other applicable state and federal law.

I make this authorization for the following health care professionals:

- any physician, health care professional, dentist, health plan, hospital, clinic, psychologist, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc. or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services.

The above-referenced persons and entities are authorized to give, disclose and release to my Personal Representative, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse. The purpose of the use and disclosure shall include assistance by my Personal Representative in monitoring my health care, sharing health care status with family and friends for my benefit, assuring my maximum access to health care rights and government benefits, monitoring my health care to protect my legal rights and providing information to my agent(s) under durable powers of attorney for health care and for finances, to the successor trustee under the Amended and Restated Langer Revocable Living Trust, and to my lawyer.

The authority given my Personal Representative shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. I understand that once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by The Privacy Rule and could be re-disclosed by the person or agency that receives it. I authorize but do not require my Personal Representative, in his or her sole discretion, to make such secondary disclosure(s) as my Personal Representative in good faith believes is appropriate and in my best interest.

The authority given my Personal Representative shall expire two (2) years after my death unless I revoke the authority in a written notice signed by me in the presence of two witnesses at any time when I have capacity to do so. Such notice shall be delivered to my health care provider, and is not effective until my health care provider receives it. I understand a written notice of revocation is not effective with respect to actions my health care provider took in reliance on this Authorization.

Dated this 31st day of August, 2010.

In the presence of:

RICHARD J. LANGER

Barbara J. Hemmer

POWER OF ATTORNEY FOR HEALTH CARE

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 and your marriage is annulled or you are divorced after signing this document, the document is invalid.

You also may 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 document 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.

Keep this page with your completed Power of Attorney for Health Care document.

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 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 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 _____

OPTIONAL - ADDENDUM TO THE POWER OF ATTORNEY FOR HEALTH CARE

If I am in a terminal condition, a persistent vegetative state, or have advanced dementia or other similar mental incapacity or have a permanent disability that prevents me from communicating my wishes, I direct my Power of Attorney for Health Care to carry out my wishes. My wishes include:

Agree	Disagree	
☐	☐	Do not use feeding tubes, including stomach tubes, nasogastric tubes, which are placed down the nose, or intravenous feedings, except to increase my comfort or reduce my pain.
☐	☐	Do not perform any surgical procedures, except to increase my comfort or reduce my pain.
☐	☐	Do not use antibiotics, except to increase my comfort or reduce my pain.
☐	☐	Do not do any testing which may cause me any distress, except to increase my comfort or reduce my pain.
☐	☐	Do not do any radiation or chemotherapy, except to increase my comfort or reduce my pain.
☐	☐	Do not use any resuscitation or advanced life support. This includes machines to help breathing or medications to maintain the heart and blood pressure.
☐	☐	Do not do kidney dialysis, either peritoneal or hemodialysis.
☐	☐	Err on the side of over-medication rather than under-medication for pain, even if taking such may result in my death. For me, the goal of pain management is total relief of pain regardless of the risks.
☐	☐	Be an active advocate as my Power of Attorney for Health Care. Do not simply give in to decisions that physicians make. Ask questions and understand proposals, challenge assumptions and be prepared to say no to care which I would not want and to demand care that I would want.
☐	☐	Remember that I want to be an organ and tissue donor. If the requirements for organ donation conflict with my wishes above, I direct that such actions be taken so as to preserve organ function and permit organ donation to occur.

Describe the level of disability you are willing to accept_____

_____

Other thoughts _____

_____

Signature of Principal_____ Date _____

Signature of Witness Number 1_____ Date _____

Signature of Witness Number 2_____ Date _____

As used in this Addendum, I intend that the following terms have the following meanings:

Terminal Condition: This is an incurable condition, caused by injury or illness, that will cause death in the near future, so that life-sustaining procedures only prolong the dying process.

Persistent Vegetative State: This is an incurable condition in which one loses the ability to think, speak and move purposefully but the heartbeat and breathing continue. Periods of sleep and wakefulness occur.

Advanced Dementia/Senility: This is severe incurable, progressive brain damage caused by strokes, injury, infection or Alzheimer's Disease, that leads to the loss of the ability to communicate with people, to recognize family and friends, and to provide for one's needs.

Residents of Wisconsin must attach this notice statement to each copy of FIVE WISHES. You may copy this form.

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00085 (Rev. 01/09)

STATE OF WISCONSIN
Chapter 155.30(1),(3)
Effective Date: January 1, 2009
608 266-1251

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 AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED 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.

FIVE WISHES®

MY WISH FOR:

The Person I Want to Make Care Decisions for Me When I Can't

The Kind of Medical Treatment I Want or Don't Want

How Comfortable I Want to Be

How I Want People to Treat Me

What I Want My Loved Ones to Know

Richard Langer

print your name

6/10/1944

birthdate

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Five Wishes

There are many things in life that are out of our hands. This Five Wishes document gives you a way to control something very important—how you are treated if you get seriously ill. It is an easy-to-complete form that lets you say exactly what you want. Once it is filled out and properly signed it is valid under the laws of most states.

What Is Five Wishes?

Five Wishes is the first living will that talks about your personal, emotional and spiritual needs as well as your medical wishes. It lets you choose the person you want to make health care decisions for you if you are not able to make them for yourself. Five Wishes lets you say exactly how you wish to be treated if you get seriously ill. It was written with the help of The American Bar Association's Commission on Law and Aging, and the nation's leading experts in end-of-life care. It's also easy to use. All you have to do is check a box, circle a direction, or write a few sentences.

How Five Wishes Can Help You And Your Family

- It lets you talk with your family, friends and doctor about how you want to be treated if you become seriously ill.
- Your family members will not have to guess what you want. It protects them if you become seriously ill, because they won't have to make hard choices without knowing your wishes.
- You can know what your mom, dad, spouse, or friend wants. You can be there for them when they need you most. You will understand what they really want.

How Five Wishes Began

For 12 years, Jim Towey worked closely with Mother Teresa, and, for one year, he lived in a hospice she ran in Washington, DC. Inspired by this first-hand experience, Mr. Towey sought a way for patients and their families to plan ahead and to cope with serious illness. The result is Five Wishes and the response to it has been overwhelming. It has been featured on CNN and NBC's Today Show and in the pages of *Time* and *Money* magazines. Newspapers have called Five Wishes the first "living will with a heart and soul." Today, Five Wishes is available in 26 languages.

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Who Should Use Five Wishes

Five Wishes is for anyone 18 or older — married, single, parents, adult children, and friends. More than 15 million people of all ages have already used it. Because it works so well, lawyers, doctors, hospitals and hospices, faith communities, employers, and retiree groups are handing out this document.

Five Wishes States

If you live in the **District of Columbia** or one of the **42 states** listed below, you can use Five Wishes and have the peace of mind to know that it substantially meets your state's requirements under the law:

Alaska	Illinois	Montana	South Carolina
Arizona	Iowa	Nebraska	South Dakota
Arkansas	Kentucky	Nevada	Tennessee
California	Louisiana	New Jersey	Vermont
Colorado	Maine	New Mexico	Virginia
Connecticut	Maryland	New York	Washington
Delaware	Massachusetts	North Carolina	West Virginia
Florida	Michigan	North Dakota	Wisconsin
Georgia	Minnesota	Oklahoma	Wyoming
Hawaii	Mississippi	Pennsylvania	
Idaho	Missouri	Rhode Island	

If your state is not one of the 42 states listed here, Five Wishes does not meet the technical requirements in the statutes of your state. So some doctors in your state may be reluctant to honor Five Wishes. However, many people from states not on this list do complete Five Wishes along with their state's legal form. They find that Five Wishes helps them express all that they want and provides a helpful guide to family members, friends, care givers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

How Do I Change To Five Wishes?

You may already have a living will or a durable power of attorney for health care. If you want to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will or durable power of attorney for health care. Or you can write "revoked" in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you. *AND*
- Tell your Health Care Agent, family members, and doctor that you have filled out a new Five Wishes. Make sure they know about your new wishes.

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WISH 1

The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

- *My attending or treating doctor finds I am no longer able to make health care choices, AND*
- *Another health care professional agrees that this is true.*

If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.

The Person I Choose As My Health Care Agent Is:

Audrey A. Langer
First Choice Name

6088317344
Phone

1502 Windfield Way
Address

Middleton / WI / 53562
City/State/Zip

If this person is not able or willing to make these choices for me, *OR* is divorced or legally separated from me, *OR* this person has died, then these people are my next choices:

Kathleen M. Langer
Second Choice Name

10138 South Statesman Place
Address

South Jordan / UT / 84095
City/State/Zip

8014467212
Phone

Michael R. Langer
Third Choice Name

625 Charles Lane
Address

Madison / WI / 53711
City/State/Zip

5039729185
Phone

Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they are too emotionally involved. Sometimes they **are** the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes. Your Health Care Agent should be **at least 18 years or older** (in Colorado, 21 years or older) and should **not** be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

I understand that my Health Care Agent can make health care decisions for me. I want my Agent to be able to do the following: **(Please cross out anything you don't want your Agent to do that is listed below.)**

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent's understanding of my wishes and values.
- Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.
- Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
- See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.
- Listed below are any changes, additions, or limitations on my Health Care Agent's powers.

If I Change My Mind About Having A Health Care Agent, I Will

- Destroy all copies of this part of the Five Wishes form. *OR*
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Agent. *OR*
- Write the word "Revoked" in large letters across the name of each agent whose authority I want to cancel. Sign my name on that page.

WISH 2

My Wish For The Kind Of Medical Treatment I Want Or Don't Want.

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.
- I want to be offered food and fluids by mouth, and kept clean and warm.

What "Life-Support Treatment" Means To Me

Life-support treatment means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a **Do Not Resuscitate** form or bracelet. Many states require a person to have a **Do Not Resuscitate** form filled out and signed by a doctor. This form lets ambulance personnel know that you don't want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a **Do Not Resuscitate** form filled out.

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Here is the kind of medical treatment that I want or don't want in the four situations listed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends and all others to know these directions.

Close to death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ☐ I want to have life-support treatment.
- ☒ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In A Coma And Not Expected To Wake Up Or Recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ☐ I want to have life-support treatment.
- ☒ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ☐ I want to have life-support treatment.
- ☒ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In Another Condition Under Which I Do Not Wish To Be Kept Alive:

If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write "end-stage condition." That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)

The next three wishes deal with my personal, spiritual and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

WISH 3

My Wish For How Comfortable I Want To Be.

(Please cross out anything that you don't agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- I wish to have my favorite music played when possible until my time of death.
- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.

WISH 4

My Wish For How I Want People To Treat Me.

(Please cross out anything that you don't agree with.)

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.

WISH 5

My Wish For What I Want My Loved Ones To Know.

(Please cross out anything that you don't agree with.)

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried or (cremated.)
- My body or remains should be put in the following location To be determined by (continued).
- The following person knows my funeral wishes: _____.

If anyone asks how I want to be remembered, please say the following about me:
See Ethical Will

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings or other specific requests that you have):
To be determined by my wife, Audrey, if possible, otherwise by my children, Kathleen and Michael

(Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Please attach a separate sheet of paper if you need more space.)

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Signing The Five Wishes Form

Please make sure you sign your Five Wishes form in the presence of the two witnesses.

I, Richard Langer, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature:_____

Address: 1502 Windfield Way Middleton, WI 53562

Phone: 6083476948 Date:_____

Witness Statement - (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age and am NOT:

- The individual appointed as (agent/proxy/ surrogate/patient advocate/representative) by this document or his/her successor,
- The person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person's health care provider,
- Financially responsible for the person's health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption, and,
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

(Some states may have fewer rules about who may be a witness. Unless you know your state's rules, please follow the above.)

Signature of Witness #1	Signature of Witness #2
Printed Name of Witness	Printed Name of Witness
Address	Address
Phone	Phone

Notarization - Only required for residents of Missouri, North Carolina, South Carolina and West Virginia

- If you live in Missouri, only your signature should be notarized.
- If you live in North Carolina, South Carolina or West Virginia, you should have your signature, and the signatures of your witnesses, notarized.

STATE OF_____ COUNTY OF_____

On this _____ day of _____, 20_____, the said _____, _____, and _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: _____

Notary Public

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What To Do After You Complete Five Wishes

- Make sure you sign and witness the form just the way it says in the directions. Then your Five Wishes will be legal and valid.
- Talk about your wishes with your health care agent, family members and others who care about you. Give them copies of your completed Five Wishes.
- Keep the original copy you signed in a special place in your home. Do NOT put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.
- Fill out the wallet card below. Carry it with you. That way people will know where you keep your Five Wishes.
- Talk to your doctor during your next office visit. Give your doctor a copy of your Five Wishes. Make sure it is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them. Ask him or her to tell other doctors who treat you to honor them.
- If you are admitted to a hospital or nursing home, take a copy of your Five Wishes with you. Ask that it be put in your medical record.
- I have given the following people copies of my completed Five Wishes:

  Audrey A. Langer

Residents of Wisconsin must attach the Wisconsin notice statement to Five Wishes.
More information and the notice statement are available at www.agingwithdignity.org or 1-888-594-7437.

Residents of Institutions In California, Connecticut, Delaware, Georgia, New York, North Dakota, South Carolina, and Vermont Must Follow Special Witnessing Rules.

If you live in certain institutions (a nursing home, other licensed long term care facility, a home for the mentally retarded or developmentally disabled, or a mental health institution) in one of the states listed above, you may have to follow special "witnessing requirements" for your Five Wishes to be valid. For further information, please contact a social worker or patient advocate at your institution.

Five Wishes is meant to help you plan for the future. It is not meant to give you legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.

Five Wishes Wallet Card

Important Notice to Medical Personnel:
I have a Five Wishes Advance Directive.

Signature

Please consult this document and/or my Health Care Agent in an emergency. My Agent is:

Audrey A. Langer
Name
1502 Windfield Way / Middleton / WI / 53562
Address City/State/Zip
6088317344
Phone

My primary care physician is:

Dr. David J. Ciske
Name
20 South Park St. / Madison / WI / 53715
Address City/State/Zip
6082872440
Phone

My document is located at:
Home

Cut Out Card, Fold and Laminate for Safekeeping

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Here's What People Are Saying About Five Wishes:

"It will be a year since my mother passed on. We knew what she wanted because she had the Five Wishes living will. When it came down to the end, my brother and I had no questions on what we needed to do. We had peace of mind."

Cheryl K.
Longwood, Florida

"I must say I love your Five Wishes. It's clear, easy to understand, and doesn't dwell on the concrete issues of medical care, but on the issues of real importance—human care. I used it for myself and my husband."

Susan W.
Flagstaff, Arizona

"I don't want my children to have to make the decisions I am having to make for my mother. I never knew that there were so many medical options to be considered. Thank you for such a sensitive and caring form. I can simply fill it out and have it on file for my children."

Diana W.
Hanover, Illinois

To Order:

Call (888) 5-WISHES to purchase more copies of Five Wishes, the Five Wishes DVD, or Next Steps guides. Ask about the "Family Package" that includes 10 Five Wishes, 2 Next Steps guides and 1 DVD at a savings of more than 50%. For more information visit Aging with Dignity's website, or call for details.

(888) 5-WISHES or (888) 594-7437

www.agingwithdignity.org

Aging with Dignity

P.O. Box 1661
Tallahassee, Florida 32302-1661

Comments

WISH 5

My body or remains should be put in the following location: (continued from p. 9)

... my wife, Audrey, if possible, otherwise by my children, Kathleen and Michael

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