

## **Medical Certification of Capacity for Determining a Patient's Representative Authority to Act**

### **Instructions**

This form is the written statement prepared by a physician or advanced practice clinician who has determined that an individual is incapacitated pursuant to Wis. Stat. § 50.06. The purpose of this form is to determine if the patient's representative has authority to act.

Copies of this completed form should be included in the patient's health care records. Within 72 hours following admission to the post-hospital facility, this form is to be filed with the register in probate for the county in which the incapacitated individual resides and sent to the adult protective services agency for the county in which the incapacitated individual resides.

### **Patient information**

Name (Last, First, MI): \_\_\_\_\_

Date of birth: \_\_\_\_\_

Permanent address – Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name of patient's representative: \_\_\_\_\_

Due to the patient's health care needs, will post-hospital facility placement be necessary?

Yes  No  Other, specify: \_\_\_\_\_

Name of post-hospital receiving facility: \_\_\_\_\_

### **Medical determination of incapacity**

On (date(s)) \_\_\_\_\_ at (location) \_\_\_\_\_

(Name of patient) \_\_\_\_\_

was personally examined by two physicians or a physician and advanced practitioner who have determined that the patient is incapacitated.

The medical conditions of the individual that led to the current assessment that the patient is incapacitated is/are:

### **Physician attestation**

I have personally examined the patient and have determined that he or she is unable to receive and evaluate information effectively or communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions, including decisions about his or her post-hospital care and that his or her incapacity is not due to mere old age, eccentricity, or physical disability, either singly or together.

I am not a relative, as defined in s. 242.01 (11), Wis. Stats., of the patient and, to the best of my knowledge, I am not entitled to or have a claim on any portion of the patient's estate.

**Physician 1**

**Signature** — Physician 1: \_\_\_\_\_

Name — Physician 1 (printed): \_\_\_\_\_

Date of attestation: \_\_\_\_\_

Office address and phone number: \_\_\_\_\_

**Physician 2/Advanced clinician**

**Signature** — Physician 2/Advanced clinician: \_\_\_\_\_

Name — Physician 2/Advanced clinician (printed): \_\_\_\_\_

Date of attestation: \_\_\_\_\_

Office address and phone number: \_\_\_\_\_

**Medical determination for regained capacity**

On (date) \_\_\_\_\_ at (location) \_\_\_\_\_

(Name of patient) \_\_\_\_\_

was personally examined by a physician or an advanced practitioner who has determined that the patient is no longer incapacitated.

The medical conditions or circumstances that led to the current assessment that the patient is no longer incapacitated is/are:

A copy of this statement will be placed in the patient's medical record and filed with the probate court and adult protective service unit for the county in which the individual resides within 72 hours of determination.

**Physician/Advanced clinician**

**Signature** — Physician/Advanced clinician: \_\_\_\_\_

Name — Physician/Advanced clinician (printed): \_\_\_\_\_

Date of attestation: \_\_\_\_\_

Office address and phone number: \_\_\_\_\_