Sequoia Integrative Medical Services

PHYSICIAN STATEMENT OF INCAPACITATION

Incapacitation Statement

Date:________________________

Time:________________________

Determination of Incapacitation

Upon evaluation of patient and medical records, it is my opinion that_________________________ (patient name) is incapacitated, that is "unable to receive and evaluate information effectively or to communicate decisions to such an extent that he/she lacks the capacity to manage his/her own health care decisions." (Wisconsin Statutes, Chapter 155.30(1)(3)

____

1. Physician Signature Date/Time

____

2. Physician/Psychologist/NP/PA Signature Date/Time

The above Individual's Power of Attorney for Health Care Agent is:

____

Printed Name of Health Care Agent Daytime Phone Number Evening Phone Number

____

Printed Name of Alternative Health Care Agent Daytime Phone Number Evening Phone Number

Recindment of Incapacitation

Upon evaluation of this patient, it is my opinion that this patient can now receive and evaluate information effectively and can communicate decisions to such an extent that he/she can manage own health care decisions.

____

Physician Signature Date/Time