

# STATEMENT OF INCAPACITY

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Date: \_\_\_\_\_

Time: \_\_\_\_\_

Patient: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

## DETERMINATION OF INCAPACITATION

Each provider below has personally examined \_\_\_\_\_ (patient name), and has determined that the patient is incapacitated, that the patient 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.” *Wis. Stat. §155.05(2)*

\_\_\_\_\_  
Dr. Katie Gesch, DO, MS, Medical Director

\_\_\_\_\_  
Date & Time

\_\_\_\_\_  
Dr. Khalid Chaudhry, MD, Psychiatrist

\_\_\_\_\_  
Date & Time

**The above individual’s Power of Attorney for Health Care Agent is:**

\_\_\_\_\_  
Printed Name of Health Care Agent

\_\_\_\_\_  
Daytime phone

\_\_\_\_\_  
Evening phone

\_\_\_\_\_  
Printed Name of Alternative Health Care Agent

\_\_\_\_\_  
Daytime phone

\_\_\_\_\_  
Evening phone

## RECINDMENT OF INCAPACITATION

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

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date & Time

*Revised 04/15/2026*

