STATEMENT OF INCAPACITY

SEQUOIA
Integrative Medical Services

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