TEXAS DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of the document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

Directive

I _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible;

OR

_____I request that I be kept alive in this terminal condition using available life-sustaining treatment. **(This selection does not apply to Hospice care.)**

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible;

OR

_____I request that I be kept alive in this irreversible condition using available life-sustaining treatment. **(This selection does not apply to Hospice care.)**

Additional requests: (After discussion with your physician and/or family members, you may wish to consider checking specific requests in this space that you do or do not want if you have a terminal or irreversible condition and can no longer communicate your wishes). Initial the statements that match what you would desire. If you do not initial a statement, then you are leaving your medical power of attorney to decide. There is room to make additional requests at the end of this document.) Only initialed statements are endorsed and indicate my desires. Statements made in this section override those made in the prior section

_____I request that if my heart should stop beating and my lungs should stop breathing that no efforts at resuscitation should be made

OR

_____I request that if my heart should stop beating and my lungs should stop breathing that all resuscitation efforts should be made.

_____I request that if clinically appropriate and offered by my physician, artificial nutrition and hydration be withheld or removed

OR

_____I request that if clinically appropriate and offered by my physician, artificial nutrition and hydration always be given.

_____I request that if clinically appropriate and offered by my physician, intravenous antibiotics be withheld or removed

OR

_____I request that if clinically appropriate and offered by my physician, intravenous antibiotics be given.

_____I request that if clinically appropriate and offered by my physician, dialysis be withheld or removed

OR

_____I request that if clinically appropriate and offered by my physician, dialysis be given.

_____I request that if clinically appropriate and offered by my physician, blood and blood products be withheld or removed

OR

_____I request that if clinically appropriate and offered by my physician, blood and blood products be given.

_____I request that if clinically appropriate and offered by my physician, respiratory support should be withheld or withdrawn

OR

_____I request that if clinically appropriate and offered by my physician, respiratory support should be given.

_____If there is a clinical experiment which has a chance of benefiting me, then I give my decision maker permission to consent for my participation

OR

_____If there is a clinical experiment, which has no chance of benefiting me, then I give my decision maker permission to consent for my participation.

_____I request that if clinically appropriate and offered by my physician, surgery intended to prolong my life (as opposed to be palliative or provide comfort) should not be done

OR

_____I request that if clinically appropriate and offered by my physician, surgery intended to prolong my life (as opposed to be palliative or provide comfort) should be done.

_____Quality of life is more important to me than quantity

OR

_____Quantity of life is more important to me than quality.

_____I wish to be free from pain even if it shortens my life.

Other Requests: _____

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I have not designated a medical power of attorney, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas.

_____If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. (applies only if initialed)

OR

_____If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I still wish that all efforts be made to sustain my life (applies only if initialed).

I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed_____ Date_____

_____
City, County, State of Residence

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness (1) may not be a person designated to make a treatment decision for the patient and may not be related to the declarant by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be

the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness (1) _____ _____
Print Name Signature

Witness (2)_____ _____
Print Name Signature

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.

Definitions:
"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:
a. that may be treated, but is never cured;
b. that leaves a person unable to care for or make decisions for the person's own self; and

c. that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both lifesustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

DISCLOSURE STATEMENT FOR MEDICAL POWER OF ATTORNEY

This is an important legal document.
Before signing this document, you should know these important facts:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

This Power of Attorney is not valid unless it is signed in the presence of two competent adult witnesses. The following persons may not act as ONE of the witnesses:

- the person you have designated as your agent.
- a person related to you by blood or marriage;
- a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- your attending physician;

• an employee of your attending physician;
• an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of a health care facility or of any parent organization of the health care facility; or
• a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

TEXAS MEDICAL POWER OF ATTORNEY

Designation of Health Care Agent:

I, _____(insert your name) appoint:

Name:_____

Address:_____

Phone:_____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

Limitations On The Decision Making Authority Of My Agent Are As Follows: _____

_____

_____

_____

Designation of an Alternate Agent:
(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s), to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name:_____

Address:_____

Phone: _____

B. Second Alternate Agent

Name:_____

Address:_____

Phone: _____

The original of the document is kept at _____
_____

The following individuals or institutions have signed copies:
Name:_____

Address:_____

Name:_____

Address: _____

Duration
I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(If Applicable) This power of attorney ends on the following date: _____

Prior Designations Revoked
I revoke any prior medical power of attorney.

Acknowledgement of Disclosure Statement
I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in this disclosure statement.

(You Must Date and Sign This Power of Attorney)
I sign my name to this medical power of attorney on _____day of _____, 20___ at
_____
(City and State)

_____
(Signature)

_____
(Print Name)

Statement of First Witness
I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care

to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature:_____

Print Name:_____ Date:_____

Address:_____

Signature of Second Witness

Signature: _____

Print Name:_____ Date:_____

Address: _____

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