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DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Instructions for completing this document:

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 this 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 an Anatomical Gift Declaration related to the donation of organs and tissues.

DIRECTIVE

I, **FIELD(P)**, IFNOTBLANK(OtherP)also known as **FIELD(OtherP)**, ENDIF 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 or treatment 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:

[INITIAL YOUR CHOICE, CROSS OUT THE OTHER]

_____ *Initials* 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**

_____ *Initials* 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 care:

[INITIAL YOUR CHOICE, CROSS OUT THE OTHER]

_____ *Initials* 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**

_____ *Initials* I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional Requests

*(After discussion with your physician, you may wish to consider listing particular treatments in this space that you **do or do not want** in specific circumstances, such as artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you **do or do not want** the particular treatment.)*

_____

_____

Artificial Nutrition and Hydration

_____ *Initials* I DO NOT WANT artificially administered nutrition and hydration. *(If this is not selected, your choice is that you DO WANT artificial nutrition and hydration.)*

Decisions Regarding Life Sustaining Treatment

_____ *Initials* The decision whether to discontinue or withhold life sustaining treatment shall be made jointly by my physician and: (i) my agent(s) under my Medical Power of Attorney in effect at that time, if any, otherwise (ii) my spouse, otherwise (iii) my reasonably available adult children, otherwise (iv) my parents, otherwise (v) my nearest living relative. *(If this is not selected, your choice is that your physician will make the decision.)*

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 will be provided and I will not be given available life-sustaining treatments.

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. IF("VARIABLE(vSex)" = "F")I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. ENDIF This directive will remain in effect until I revoke it. No other person may do so.

SIGNED on this IF(VARIABLE(vOneStep))EMBEDMACRO(BookmarkCreate("ProofReadHere"))ELSE MRGCMND(EMBEDMACRO(BookmarkCreate("ProofReadHere")))ENDIF the IF(VARIABLE(vOneStep))VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear)ELSE MRGCMND(VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear))ENDIF .

_____
FIELD(P)
FIELD(AddressP)IFNOTBLANK(CityStateZipP)
FIELD(CityStateZipP)ENDIF

STATE OF TEXAS §
§
COUNTY OF IF(VARIABLE(vOneStep))TOUPPER(VARIABLE(vCounty))ELSE MRGCMND(TOUPPER(VARIABLE(vCounty)))ENDIF §

BEFORE ME, THE UNDERSIGNED AUTHORITY, on this day personally appeared FIELD(P), who stated that IF("TOUPPER(SUBSTR(FIELD(SexP);1;1))"="F")sENDIF he executed the above document for the purposes and considerations therein expressed.

GIVEN under my hand and seal of office on this the IF(VARIABLE(vOneStep))VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear)ELSE MRGCMND(VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear))ENDIF .

_____

Notary Public, State of Texas

DEFINITIONS

"**Artificially administered 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 gastrointestinal tract.

"**Irreversible condition**" means a condition, injury, or illness:

(1) that may be treated, but is never cured or eliminated;

(2) that leaves a person unable to care for or make decisions for the person's own self; and

(3) 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 life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration. 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.*