DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES
Advance Directives Act (see §166.033, Health and Safety Code)

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 listed on page 5 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
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 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:

__________ 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, 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.)

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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 do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make health care or treatment decisions with my physician compatible with my personal values:

1. ___________________________________________________________________
2. ___________________________________________________________________

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available or if I have not designated a spokesperson, 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. 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.

This document must be signed either before a notary or before two witnesses.
OPTION 1: SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this directive on the _________ day of

______________________________ (month, year) at

_____________________________________________
(City and State)

_____________________________________________
(Signature)

_____________________________________________
(Print Name)

State of Texas
County of __________________

This instrument was acknowledged before me on __________ (date)
by ______________________ (name of person acknowledging).

___________________________________________
NOTARY PUBLIC, State of Texas

Notary’s printed name:

___________________________________________
My commission expires:
OPTION 2: SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this directive on the __________ day of __________________________ (month, year) 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: ________________________________________________ Date:__________________

Print Name: ____________________________________________ Address:______________________________________________________________

SIGNATURE OF SECOND WITNESS

Signature: ________________________________________________ Date:__________________

Print Name: ____________________________________________ Address:______________________________________________________________
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.