DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

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 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) <u>should not be</u> 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) <u>should be</u> 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 patient 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