Directive to Physicians

For Persons 18 years of Age and Over

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, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, 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 treatment decisions with my physician compatible with my personal values.

Name _____

Address _____

Name _____

Address _____

(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. I understand that I may revoke this DIRECTIVE at any time.

I understand the full import of this DIRECTIVE and I am emotionally and mentally competent to make this DIRECTIVE.

Signed _____

City, County and State of Residence _____

Date _____

Two competent witnesses must sign below, acknowledging your signature. 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. The witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. The witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of the 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 the health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____

Witness 2 _____

Medical Power of Attorney Form

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 my physician certifies this fact in writing.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____
_____
_____
_____

Designation of 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 persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____

_____

Phone: _____

Second Alternate Agent

Name: _____

Address: _____

_____

Phone: _____

The original of this document is kept at_____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

_____

Phone: _____

Name: _____

Address: _____

_____

Phone: _____

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.

Acknowledgment of Disclosure Statement

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

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Medical Power of Attorney on

_____ day of _____ month _____ year

at_____.
(City and State)

_____
(Signature)

_____
(Print Name)

Statement of Witness

I am not the person appointed an 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: _____

Address: _____

_____

Date: _____

Signature: _____

Print Name: _____

Address: _____

_____

Date: _____