

## 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 help you complete 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 want to talk to your physician, family, hospital representative, or other advisers about them. You may also want to make a directive for organ and tissue donation.

You will need **two** witnesses to sign this Directive to acknowledge your signature. Both witnesses must be at least 18 years old, and competent (in good mental health).

And, "Witness 1" must **not** be:

- someone you have asked to make health care decisions for you.
- a person who is related to you by blood or marriage.
- a person who has a right to any part of your estate. (This person is not allowed to make a claim against your estate.)
- your attending physician or an employee of your attending physician.
- an officer, director, partner, or business office employee of the health care facility where you are being cared for, or of any parent organization of the health care facility. (If Witness 1 is an employee of a health care facility where you are being cared for, s/he must not be directly involved in your care.)

In lieu of the two witnesses, you can sign the Directive before a notary public.

---

## 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 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.)**

**Other requests:** (After talking to your physician, you may want to list 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: (You do not need to fill out this part, if you already have a valid Medical Power of Attorney.)

1.

---

2.

---

If the people listed above 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.

Date: \_\_\_\_\_

---

\_\_\_\_\_  
Type or print name your name here

\_\_\_\_\_  
Sign here

Your address (City, County, State)

---

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.

\_\_\_\_\_ ▶  
\_\_\_\_\_ ▶  
Type or print name of Witness 1                      Witness 1 signs here

\_\_\_\_\_ ▶  
\_\_\_\_\_ ▶  
Type or print name of Witness 2                      Witness 2 signs here

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:

- (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



therein expressed.

---

Declarant (Your Name)

**SUBSCRIBED AND ACKNOWLEDGED BEFORE ME** by the said Declarant,

\_\_\_\_\_ on this the \_\_\_\_ day of \_\_\_\_\_,  
20\_\_\_\_.

---

Notary Public in and for  
The State of Texas