ELLENBECKER PERSONALIZED MEDICINE

Modern Care, Intentional Focus

ADVANCE DIRECTIVE

Directive to Physicians and Family or Surrogates, and Medical Power of Attorney — Texas Health and Safety Code, Chapter 166

This document provides the statutory forms recognized under Texas law. Completing either or both is voluntary. You are encouraged to discuss your wishes with your physician and your family before signing.

PART I — 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. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness: the Medical Power of Attorney (Part II of this document) and the Out-of-Hospital Do-Not-Resuscitate Order. 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 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 (e.g., artificially administered nutrition and hydration, intravenous antibiotics). 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 here.)

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.

Signed: _____ **Date:** _____

City, County, State of Residence: _____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. Witness 1 may not be a person designated to make a health care or treatment decision for the patient, may not be related to the patient by blood or marriage, may not be entitled to any part of the estate, and may not have a claim against the estate. Witness 1 may not be the attending physician or an employee of the attending physician, and if an employee of a health care facility in which the patient is being cared for, may not be involved in providing direct patient care or be an officer, director, partner, or business office employee of the facility or its parent organization.

Witness 1 Signature: _____ **Date:** _____

Witness 2 Signature: _____ **Date:** _____

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 that may be treated but never cured or eliminated, that leaves a person unable to care for or make decisions for their own self, and that, without life-sustaining treatment, is fatal. Many serious illnesses such as cancer, organ failure, and serious brain disease may be considered irreversible early on — the patient may be kept alive for prolonged periods with treatment. Late in the illness, the disease may be considered terminal when, even with treatment, the patient is expected to die.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die — including life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis, and artificially administered nutrition and hydration. It does not include pain management medication, comfort care procedures, or care provided to alleviate 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.

PART II — MEDICAL POWER OF ATTORNEY: 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 this fact is certified in writing by my physician.

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. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless this document provides otherwise.)

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, in the following order:

A. First Alternate Agent

Name: _____

Address: _____

Phone: _____

B. Second Alternate Agent

Name: _____

Address: _____

Phone: _____

The original of this document is kept at: _____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

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 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.

DISCLOSURE STATEMENT

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions. Your agent is obligated to follow your instructions when making decisions on your behalf.

It is important that you discuss this document with your physician before you sign it. You do not need a lawyer's assistance to complete this document, but if there is anything you do not understand, you should ask a lawyer to explain it.

The person you appoint as agent should be someone you know and trust, 18 years of age or older. If you appoint your health or residential care provider, that person has to choose between acting as your agent or as your provider — the law does not allow a person to serve as both at the same time.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent at any time, orally or in writing. Unless you state otherwise, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void. This document may not be changed or modified — to make changes you must execute a new medical power of attorney.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS: (1) you sign it and have your signature acknowledged before a notary public; OR (2) you sign it in the presence of two competent adult witnesses.

The following persons may not act as a witness: the person designated as your agent; a person related to you by blood or marriage; a person entitled to any part of your estate after your death; your attending physician or an employee of your attending physician; certain employees of a health care facility in which you are a patient; or a person who has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

Signature (Acknowledged Before Notary, or Signed in the Presence of Two Competent Adult Witnesses)

Signature: _____ **Date:** _____

Print Name: _____

City and State: _____

If Acknowledged Before a Notary

State of Texas, County of _____

This instrument was acknowledged before me on _____ by _____.

Notary Public, State of Texas — Printed Name: _____

My Commission Expires: _____

If Signed in the Presence of Two Competent Adult Witnesses

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. I am not the attending physician or an employee of the attending physician. I have no claim against the principal's estate. 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 and am not an officer, director, partner, or business office employee of the facility or its parent organization.

Witness 1 Signature: _____ **Date:** _____

Witness 1 Printed Name & Address: _____

Witness 2 Signature: _____ **Date:** _____

Witness 2 Printed Name & Address: _____