**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, medical institution or attorney may provide you with various resources to assist you in completing 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 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.**

**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.

**Written Directive by Competent Adult**

This Written Directive by Competent Adult (“Written Directive”) is made pursuant to Tex. Health & Safety Code Ann. § 166.032 and includes directions other than those provided by §166.033 of the Texas Health & Safety Code. In signing this Written Directive, I willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth herein. In executing this Written 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.)

**ARTIFICIAL NUTRITION AND HYDRATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By initialing this sentence, I signify that I understand that sustenance (food) and hydration (water) are considered life-prolonging procedures and are to be withheld or withdrawn in accordance with this Written Directive. [OBJ:LIVWST-FL 1006]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By initialing this sentence, I signify that I understand that hydration (water) is considered a life-prolonging procedure and is to be withheld or withdrawn in accordance with this Written Directive; however, notwithstanding anything herein to the contrary, I desire that I be provided sustenance (food). [OBJ:LIVWST-FL 1007]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By initialing this sentence, I signify that I understand that nutrition (food) is considered a life-prolonging procedure and is to be withheld or withdrawn in accordance with this Written Directive; however, notwithstanding anything herein to the contrary, I desire that I be provided hydration (water). [OBJ:LIVWST-FL 1008]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Notwithstanding anything herein to the contrary, by initialing this sentence, I signify my desire that I be provided sustenance (food) and hydration (water). [OBJ:LIVWST-FL 1009]

**ORGAN DONATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By initialing this sentence, I hereby make the following anatomical gift(s), if medically acceptable, to take effect on my death: [OBJ:LIVWST-FL 1010]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I give the following, for the purpose of transplantation, therapy, medical research, or education: [OBJ:LIVWST-FL 1012]

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ any needed organs, tissues, or eyes; [OBJ:LIVWST-FL 1013]

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_only the following organs, tissues, or eyes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; [OBJ:LIVWST-FL 1014]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I give my body for anatomical study if needed, subject to the following limitations or special wishes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if applicable, list specific donee; this must be arranged in advanced with the donee) [OBJ:LIVWST-FL 1015]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notwithstanding anything contained herein to the contrary, by initialing this sentence, I acknowledge that I have elected to be an organ donor and request that my attending or treating physician undertake any and all reasonable and prudent steps to fulfill my wishes to be an organ donor, including postponing the withdrawal of, or instituting for a reasonable period of time, any life-prolonging procedures as necessary to permit the timely and prudent donation of my organs. [OBJ:LIVWST-FL 1016]

**DESIGNATION OF PERSONS**

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 Written Directive has no effect if I have been diagnosed as pregnant. This Written Directive will remain in effect until I revoke it. No other person may do so.

In the absence of my ability to give directions regarding the use of life-prolonging procedures or life-continuing machines, it is my intention that this Written Directive shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. [OBJ:LIVWST-FL 1018]

I understand the full import of this Written Directive and I am emotionally and mentally competent to make it. [OBJ:LIVWST-FL 1020]

Notwithstanding anything herein to the contrary, if I have been diagnosed as pregnant and that diagnosis is known to my attending or treating physician, this Written Directive shall have no force or effect during the course of my pregnancy. [OBJ:LIVWST-FL 1021]

The terms used herein shall have the same meaning as those terms defined pursuant to Chapter 166 of the Texas Health & Safety Code, as amended. Should any specific direction of this Written Directive be held invalid for any reason, such invalidity shall not affect the enforceability of the remainder of this Written Directive. [OBJ:LIVWST-FL 1022]

Signed on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Declarant

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WITNESSES**

On the date that this declaration was signed, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Declarant”) requested that I witness his/her/their signature. I am a competent adult, capable of witnessing this Written Directive. As a witness to this Written Directive, I acknowledge the Declarant’s signature above and that I witnesses the Declarant sign this Written Directive. As a witness, I am not:

1. a person designated to make a health care or treatment decision for the Declarant;
2. related to the declarant by blood or marriage;
3. entitled to any part of the estate of the Declarant;
4. a claimant against the estate of the Declarant;
5. the attending physician or an employee of the attending physician
6. involved in providing direct patient care to the Declarant, if I am an employee of a health care facility in which the Declarant is being cared for; or
7. an officer, director, partner, or business office employee of a health care facility in which the Declarant is being cared for or of any parent organization of the health care facility.

WITNESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note to Physicians, Medical Personnel and Health Care Facilities**

**The foregoing Written Directive is executed under § 166.033 or §166.035 of the Texas Health & Safety Code. The signatures above are not notarized. Pursuant to the Texas Health & Safety Code, the foregoing Written Directive is effective without regard to whether it is notarized. Further, a physician, health care facility, or health care professional may not require that a Written Directive (1) be notarized; or (2) a person use a form provided by the physician, health care facility, or health care professional.**