Advance Care Planning Tip Sheet

How to Fill Out Directive to Physicians, Families or Surrogates

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. Your physician, other health care provider or medical institution 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 facility, 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, facility representative, or other advisers. 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:

_____ INITIALS I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allows me to die as gently as possible; OR

_____ INITIALS 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 medical care:

_____ INITIALS I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allows me to die as gently as possible; OR

_____ INITIALS 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 artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.

Example: *I do not want a PEG tube or artificial nutrition at the end of life.*

Only ONE name goes here. Do not put in Mr. and Mrs. Smith. Each person must complete their own form, even if information is identical

Each of these sections have a choice. Initial one choice in each section. DO NOT initial all of these.

This section can be left blank. Your Agent can make decisions without this being filled in. Fill in this section to indicate specific wishes you want or do not want as an option. You cannot plan for every scenario.

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Fill out ONLY if you did not complete the Medical Power of Attorney paperwork.

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. *First and last name of person you wish to make decisions on your behalf and their relationship to you.*

2. *First and last name of person you wish to make decisions on your behalf and their relationship to you.*

(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.

Signed *Sign Your Name* Date *January 1, 2020*

City, County, State of Residence *Your City, Your County, Your State*

You must have 2 witnesses for this document to be valid. You can choose to use a notary instead of 2 witness. This document is FREE. An attorney is not required to complete this document.

Witnesses

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 health care or 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 *First and last name of the person you wish to make the decision on your behalf*

Witness 2 *First and last name of the person you wish to make the decision on your behalf*

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