Directive to Physicians and Family or Surrogates

HBV04222005

Disclosure Statement for 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 assist you in completing your Advance Directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initiate 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 the document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this Advance Directive, Texas law provides for other types of directives that can be important during a serious illness. Two such documents 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 advisors. You may also wish to complete a directive concerning your desires for donation of organs and tissues.

Directive to Physicians and Family or Surrogates (Directive)

I, ________________________________, recognize that the best health care is based upon a relationship 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 be 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 (mark desired selection below):

☐ 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 section 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 I am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care (mark desired selection below):

☐ 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 section does not apply to hospice care.)**

Additional Requests: After discussion with your physician, you may wish to consider listing particular treatments in this section 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 particular treatments.

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After signing this directive, if my representative or I elect hospice care, I understand and agree that only those care treatments needed to keep me comfortable will be provided and that I will not be given 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 that are compatible with my personal values:

1. ____
   Name Address Phone Number

2. ____
   Name Address Phone Number

If a Medical Power of Attorney has been executed, then an agent has already 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.

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Declarant Address City County State Date

Two 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 declarant by blood or marriage. This witness may not be entitled to any part of the declarant's estate and may not have a claim against the estate. The 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 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 declarant is being cared for or of any parent organization of the health care facility.

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Witness 1 Address Date

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Witness 2 Address Date