



## **Advance Directives**

### **What is an advance directive?**

An advance directive is a document that spells out your wishes regarding what kind of care and medical treatment you would want if you become unable to speak for yourself.

### **Why should I have advance directives?**

We respect your right to choose the care you want to receive. An advance directive is a clear way to communicate your wishes to us. It is also important to communicate your wishes to your family, personal physicians, and other healthcare providers so that there are no misunderstandings or disagreements within your family at a difficult time of your and their lives.

### **Instructions for completing an Advance Directive**

1. It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.
2. A competent adult may at any time execute a written directive.
3. A person must sign the directive in the presence of two witnesses.
4. The witnesses must sign the directive where indicated.
5. A person may include directions other than those included and may designate a person to make a treatment decision for the person in the event the person becomes incompetent or otherwise mentally or physically incapable of communication.
6. Advance directives do not need to be notarized.
7. A directive is effective until it is revoked.
8. A person may revoke a directive at any time by indicating "Revoked" across the face of the directive.
9. A person may not withhold cardiopulmonary resuscitation (CPR) or certain other life-sustaining treatment from a person known by the responding health care professionals to be pregnant.
10. Provide a copy of your directive to your physician, Central Texas Medical Center, family members and your medical powers of attorney (if so designated)
11. You should review your advance directives periodically to ensure that the information is still current and reflective of your wishes.

**For more information about Advance Directives, call 753-3653 or visit our website at [www.ctmc.org](http://www.ctmc.org) and click on "Patients and Visitors".**

**DIRECTIVE TO PHYSICIAN (“LIVING WILL”)**

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.)

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 artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

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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:

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:

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 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 \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

\_\_\_\_\_, County \_\_\_\_\_, State of Texas

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.

Witness 1 \_\_\_\_\_

Witness 2 \_\_\_\_\_

## **INFORMATION CONCERNING THE MEDICAL POWER OF ATTORNEY**

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 no longer capable of making them yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. 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 begins 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. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf. Even after 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 by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

**THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:**

- the person you have 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 under a will or codicil executed by you or by operation of law;
- your attending physician;
- an employee of your attending physician;
- an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

**MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT**

I, \_\_\_\_\_ 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 as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

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 to make health care decisions for me as authorized by this document, who serve 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 the time 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.

**ACKNOWLEDGMENT OF DISCLOSURE STATEMENT:**

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this medical power of attorney on \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ at

\_\_\_\_\_  
(City and State)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print Name)

**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 on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death.

Furthermore, 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 to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

**SIGNATURE OF SECOND WITNESS:**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_