INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS 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 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 capacity 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.

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.

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 durable power of attorney for health care. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

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 OR MORE QUALIFIED WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

(1) the person you have designated as your agent:

(2) your health or residential care provider or an employee of your health or residential care provider;

(3) your spouse;

(4) your lawful heirs or beneficiaries named in your will or a deed; or

(5) creditors or persons who have a claim against you.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
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 durable power of attorney for health care 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:

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 durable power of attorney for health care.

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 durable power of attorney for health care on the ___ day of

_____, 20__ at _____.
(City and State)

(Signature)

(Print Name)

STATEMENT OF WITNESSES.

I declare under penalty of perjury that the principal has identified himself or herself to me, that the principal signed or acknowledged this durable power of attorney in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed agent by this document, and that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature:
Print Name:
Date:
Address:

Witness Signature:
Print Name:
Date:
Address:

DIRECTIVE TO PHYSICIANS
(Patient is decision-maker)

Directive made this __ day of _____ (month, year).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth in this directive.

1. If at any time I should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and if the application of life-sustaining procedures would serve only to artificially postpone the moment of my death, and if my attending physician determines that my death is imminent or will result within a relatively short time without the application of life-sustaining procedures, I direct that those procedures be withheld or withdrawn, and that I be permitted to die naturally.

a. (Optional) I further direct that when I become comatose, or when I become so weak that I cannot swallow water and food, that no feeding tube or other similar artificial apparatus be attached to or inserted into any part of my body to provide nourishment or to prevent dehydration.

PATIENT CHOOSES THIS OPTION _____ (initials)

PATIENT DECLINES THIS OPTION _____ (initials)

b. (Optional) It is my intention that artificial means of support, including nutrition and hydration, be withheld or withdrawn if I should be diagnosed as being a permanently unconscious state where, in reasonable medical probability, there will not be a return of cognitive brain function enabling me to think and live in a human way.

PATIENT CHOOSES THIS OPTION _____ (initials)

PATIENT DECLINES THIS OPTION _____ (initials)

EXCEPTION(S). I do not authorize the following:

_____

2. In the absence of my ability to give directions regarding the use of such those life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. (For female patients) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no effect during my pregnancy.

4. This directive shall be in effect until it is revoked.

5. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

6. I understand that I may revoke this directive at any time.

7. If I am comatose, incompetent, or otherwise mentally or physically incapable of communication, I designate _____, to make treatment decisions concerning my medical condition, including decisions carrying out the terms of this directive.

Signed:

Address:

(City, County, State of Residence)

WITNESSES

I am not related to the declarant by blood or marriage; I would not be entitled to any portion of the declarant's estate on the declarant's death. I am not the attending physician of the declarant or an employee of the attending physician. I am not a patient in the healthcare facility in which the declarant is a patient. I have no claim against any portion of the declarant's estate on the declarant's death. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant and am not directly involved in the financial affairs of the health facility.

Witness:

Witness:

CONSENT TO A "DO NOT RESUSCITATE" ORDER
(by patient)

Consent given this __ day of _____(month, year).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. In the event that I suffer cardiac or respiratory arrest, I direct that no cardiopulmonary resuscitative ("CPR") measures be performed. My attending physician, Dr. _____, measures, the benefits and harm if they are performed, and the benefits and harm if they are not performed. I am satisfied with these explanations. I understand that CPR does not refer to ordinary methods used to maintain my life, health, or comfort, such as the administration of pain aid, other appropriate medications, IV fluids, and nutritional support.

I consent to the issuance of a "Do No Resuscitate" order by my attending physician.

Limitation(s). I do not authorize the following:

2. In the absence of my ability to give directions regarding the use of CPR measures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my right to refuse CPR measures and accept the consequences from such refusal.

3. (For female patients): If I have been diagnosed as pregnant and that diagnosis is known to my physician, this consent shall have no force or effect during the course of my pregnancy.

4. I understand the importance of this consent, and I am emotionally and mentally competent to give this consent.

5. This consent shall be in effect until it is revoked. I understand that I may revoke this consent at any time.

6. I hereby release the Hospital, its personnel, my attending physician, and any other persons participating in my care from any responsibility whatsoever for unfavorable results, including death, which I understand may occur as a result of this refusal to permit CPR measures.

Signed:

Address:

WITNESSES

I am not related to the declarant (patient) by blood or marriage; nor would I be entitled to any portion of the declarant's estate on his/her decease; nor am I the attending physician of the declarant or an employee of the attending physician; nor am I a patient in the Hospital in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his/her decease. Furthermore, if I am an employee of the Hospital in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the Hospital.

Witness:

Address:

OUT-OF-HOSPITAL DO NOT RESUSCITATE ORDER

This document must accompany the Declarant during transport. The proper disposition of this document or copies of it shall be as the Texas Board of Health determines appropriate.

I, _____, ("Declarant") being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below. This order is being signed under the authority of Chapter 674 of the Health and Safety Code (the "Code") of the State of Texas, and terms used herein shall have the meaning described to them in Chapter 674 of the Code. I do hereby declare as follows:

If I have been diagnosed as having a terminal condition, then in the event that I suffer cardiac or respiratory arrest, I direct that my attending physician and all other health care professionals acting in my behalf in out-of-hospital settings should not initiate or continue life-sustaining procedures, including (without limitation) any of the following:

(i) cardiopulmonary resuscitation;
(ii) endotracheal intubation or other means of advanced airway management;
(iii) artificial ventilation;
(iv) defibrillation;
(v) transcutaneous cardiac pacing;
(vi) the administration of cardiac resuscitation medications; and
(vii) other life-sustaining procedures within the meaning of Section 674.001(13) of the Code.

I understand that I may revoke this Out-Of-Hospital Do Not Resuscitate ("DNR") order at any time by destroying the order and removing the DNR identification device, if any, or by communicating to health care professionals at the scene my desire to revoke the Out-Of-Hospital DNR order.

This document is in effect on this ___ day of _____, 20__, the date of its execution, and remains in effect until the death of the person or until the document is revoked.

_____

Declarant, (Printed or Typed Name)

Declarant, (Signature)

Address

I am the attending physician of the Declarant. I have diagnosed the Declarant as having a terminal condition, and I direct health care professionals' action in out-of-hospital settings not to initiate or continue the life-sustaining procedures specified above in this document on behalf of the Declarant.

Attending Physician:

_____

Printed Name

Signature

_____

Medical License Number

STATEMENT BY NONWRITTEN MEANS OF COMMUNICATION

The legal guardian of Declarant, Declarant's proxy, the agent of Declarant having a durable power of attorney for health care, or the attending physician attesting to the issuance of an out-of-hospital DNR order by nonwritten means of communication or acting in accordance with a previously executed or previously issued directive to physicians under Section 674.002(d) which includes the provisions provided for in Section 674.003(7)(A) & (B) directs that the life-sustaining procedures should not be initiated or continued in behalf of Declarant.

_____

Legal Guardian, Proxy, Agent or Physician (Printed or Typed Name)

Legal Guardian, Proxy, Agent or Physician (Signature)

STATEMENT BY QUALIFIED RELATIVES

_____ and _____, two qualified relatives of Declarant, are qualified to make a treatment decision to withhold cardiopulmonary resuscitation and certain other designated life-sustaining procedures under Section 674.008 of the Health and Safety Code. Based on the known desires of Declarant or a determination of the best interest of Declarant, these qualified relatives direct that the listed life-sustaining procedures should not be initiated or continue in behalf of the person; since Declarant does not have a legal guardian, proxy, or agent having a durable power of attorney for health care and Declarant is comatose, incompetent, or otherwise mentally or physically incapable of communication.

_____

Qualified Relative (Printed or Typed Name)

Qualified Relative, (Signature)

_____

Qualified Relative (Printed or Typed Name)

Qualified Relative, (Signature)

WITNESSES

I am not related to the Declarant by blood or marriage. I would not be entitled to any portion of the Declarant's estate on the Declarant's death. I am not the attending physician of the Declarant or an employee of the attending physician. I am not a patient in the health care facility in which the Declarant is a patient. I have no claim against any portion of the Declarant's estate on the Declarant's death. Furthermore, if I am an employee of a health care facility in which the Declarant is a patient, I am not involved in providing direct patient care to the Declarant and am not directly involved in the financial affairs of the health facility.

_____ _____

Witness' Name (Printed) Witness' Signature

_____ _____

Witness' Name (Printed) Witness' Signature

The undersigned, being all of the persons signing the foregoing document, hereby state that the document has been properly completed.

_____

Declarant

_____

Physician

_____

Witness