Medical Power of Attorney

Information for Patients, Physicians, and Providers

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

General Information

To be read by the patient and physician or other provider. The full advance directives statute is at Texas Health and Safety Code, Chapter 166.

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Definitions

- **Physician** means a physician licensed by the Texas Medical Board; or a properly credentialed physician who holds a commission in the uniformed services of the United States and who is serving on active duty in this state. *§166.002(12)*
- The **agent** is the adult to whom authority to make health care decisions is delegated under a medical power of attorney. *§166.151(2)*
- The **principal** is the adult who executes a medical power of attorney. *§166.151(4)*
- **Providers** are (a) health care providers — individuals or facilities licensed, certified, or otherwise authorized to administer health care, for profit or otherwise, and includes physicians, and (b) residential care providers — individuals or facilities licensed, certified, or otherwise authorized to operate, for profit or otherwise, a residential care home. *§166.151(3), (5)*

What is a medical power of attorney?

It is a document, signed by a competent adult, i.e., "principal," designating a person who the principal trusts to make health care decisions on the principal's behalf should the principal be unable to make such decisions. The individual chosen to act on the principal's behalf is referred to as an "agent."

When does the medical power of attorney go into effect and how long is it effective?

It is effective immediately after it is executed and delivered to the agent. It is effective indefinitely unless it contains a specific termination date, it is revoked, or the principal becomes competent. *§166.152*

When does the agent have the right to make health care decisions on the principal's behalf?

An agent may make health care decisions on the principal's behalf only if the principal's attending physician certifies in writing that the principal is incompetent. The physician must file the certification in the principal's medical record. *§166.151(b)*

Can the agent make a health care decision if the principal objects?

No. Treatment may not be given to or withheld from the principal if the principal objects. This is true whether or not the principal is incompetent. *§166.152(c)*

What health care decisionmaking power does the medical power of attorney grant to an agent?

Under a medical power of attorney, an agent is given wide latitude when consenting to treatment on the principal's behalf. However, an agent cannot consent to: *§166.152(f)*

- Commitment to a mental institution,
- Convulsive treatment,
- Psychosurgery,
- Abortion, and
- Neglect of comfort care.

And in the medical power of attorney document itself, the principal may limit the agent's decisionmaking authority.

How is the medical power of attorney revoked?

A medical power of attorney may be revoked by notifying either the agent or the principal's physician or provider orally or in writing, of the principal's intent to revoke. This revocation will occur regardless of the principal's capacity to make health care decisions. Further, if the principal executes a later medical power of attorney, then all prior ones are revoked. If the principal designates his/her spouse to be the agent, then a later divorce revokes the medical power of attorney. *§166.155*

What assurance is there that the principal understands the consequences of signing a medical power of attorney?

The medical power of attorney is not legally effective unless the principal signs a disclosure statement that he or she has read and understood the contents of the medical power of attorney before signing the medical power of attorney itself. *§166.162*

Information of Importance to Patients/ Principals

Do I need a medical power of attorney?

There is a chance in your lifetime that you may be seriously injured, ill, or otherwise unable to make decisions regarding health care. If this should happen, it would be helpful to have someone who knows your values and in whom you have trust to make such decisions for you.

Who should be selected as an agent?

The principal should be someone knowledgeable about your wishes, values, and religious beliefs, and in whom you have trust and confidence. In the event your agent does not know of your wishes, that agent should be willing to make health care decisions based upon your best interests.

Can there be more than one agent?

Yes. Although you are not required to designate an alternate agent, you may do so. The alternate agent(s) may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act. *§166.163*

Who can be an agent?

Anyone may act as an agent other than the following:

- The principal's physician or health care provider,
- An employee of the physician or health care provider unless the person is a relative of the principal,
- The principal's residential care provider, or
- An employee of the principal's residential care provider unless the person is the principal's relative. *§166.153*

How can you obtain a medical power of attorney?

You may contact the Texas Department of Aging and Disability Services; your local hospital, long-term care facility, physician, attorney, or a state health organization such as the Texas Conference of Catholic Health Facilities, Texas Medical Association, Texas Hospital Association, Texas Health Care Association, or the Texas Association of Homes for the Aging.

Do you need a witness?

Either two witnesses must sign the medical power of attorney, or you may sign it and have your signature acknowledged before a notary public. At least one of the witnesses must not be:

- Designated by the principal to make a health care decision on the principal's behalf;
- Related to the principal by blood or marriage;
- The principal's attending physician or an employee of the attending physician;
- Entitled to a part of the principal's estate;
- A person having a claim against the principal's estate;
- An employee of a health care facility in which the principal is a patient if the employee is providing direct care to the principal; or
- An officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility. *§166.154*

What is the difference between a medical power of attorney and a directive to physicians?

The directive to physicians is a document that is limited in scope, addressing only the withholding or withdrawing of medical treatment for those persons having a terminal or irreversible condition. The medical power of attorney is broader in scope and includes all health care decisions with only a few exceptions. The medical power of attorney does not require that the principal be in a terminal or irreversible condition before the principal's agent can make health care decisions on the principal's behalf.

Does a person need a lawyer to execute a medical power of attorney?

No, a lawyer is not necessary to execute a medical power of attorney. *§166.163*

Information of Importance to Physicians and Providers

What duties does the physician provider have when presented with a principal's medical power of attorney?

A principal's physician or provider, or an employee of the physician or provider shall follow a directive of the principal's agent to the extent it is consistent with the desires of the principal, the law, and the medical power of attorney.

The attending physician does not have to verify that the agent's decision is consistent with the principal's wishes or religious or moral beliefs. If the principal's physician or provider will not follow an agent's decision, the physician or provider must inform the agent as soon as reasonably possible. The agent may select another physician or provider.

A health or residential care provider may not be required to act in a manner contrary to a physician's order. *§166.158*

Suppose that the principal's medical power of attorney provides the agent with decisionmaking authority with regard to the provision of life-sustaining treatment. Suppose that the agent wishes to have the physician remove life-sustaining treatment from the principal, but the principal's attending physician refuses to comply with the decision? In light of this refusal, what is the responsibility of the physician and the applicable health care facility?

If the principal's attending physician refuses to honor the agent's decision, then the physician's refusal may be reviewed by a medical or ethics committee. If the ethics or medical committee reviews the refusal, the physician cannot be a member of the review committee. The principal must be provided life-sustaining treatment while the review is taking place. The agent must be given at least 48 hours' notice of when the review committee will convene and must also be allowed to attend the committee meeting. The agent must be provided a written explanation of the decision reached during the review process. If the agent or the physician disagrees with the decision reached through the review process, then the physician must make a reasonable effort to transfer the patient to a physician who is willing to comply with the agent's decision. If the principal is a patient in a health care facility, the facility's personnel shall assist the physician in arranging the principal's transfer to another physician, an alternative care setting within that facility, or another facility that will honor the agent's decision. If the process just described is followed, then the physician and the health care facility will be immune from disciplinary action, civil liability, and criminal liability. *§166.046*

Suppose that the principal's medical power of attorney provides the agent with decisionmaking authority with regard to the provision of life-sustaining treatment. Suppose that the agent wants the physician to provide life-sustaining treatment but the principal's attending physician believes that the requested treatment is inappropriate. What is the responsibility of the physician and the applicable health care facility in this case?

If the physician believes that the requested treatment is inappropriate, then an ethics or medical committee may review the requested treatment for appropriateness. Again, the physician cannot be a member of the review committee, and the patient must be provided life-sustaining treatment while the review is taking place. The agent must be allowed to attend the meeting of the review committee and must be provided a written explanation of the decision reached during the review process.

If the review process determines that the administration of the requested life-sustaining treatment is inappropriate, then the principal's physician must make a reasonable effort to transfer the patient to a physician who is willing to provide the requested treatment. The health care facility in which the patient resides must assist the physician in arranging the patient's transfer to another physician, an alternative care setting within that facility, or another facility that will provide the requested treatment. Although the physician and the health care facility are obligated

to provide life-sustaining procedures pending transfer, this obligation is limited. The physician and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after the agent receives a written notification that the review process has determined that the administration of the requested life-sustaining treatment is inappropriate. If the hospital and physician follow this process, then the physician and the health care facility will be immune from disciplinary action, civil liability, and criminal liability. *§166.046*

Is the review process described above mandatory?

No. However, even if the physician's refusal to comply with an agent's directive does not come under the review process, the physician and the health care facility must provide life-sustaining treatment. The physician and the health care facility need only provide the treatment until a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply with the directive. But because an ethics or medical committee did not review the physician's refusal, neither the physician nor the hospital will be granted immunity from disciplinary action, civil liability, or criminal liability. *§166.046*

What must be done if a physician or provider learns that a principal's medical power of attorney has been revoked?

When a physician or provider is informed of, or provided with, a revocation of a medical power of attorney, the revocation shall be recorded in the medical record and notice given to the agent. *§166.155*

What rights to the principal's medical records does the agent have?

The agent may, in the course of making a health care decision:

- Request, review, and receive information about the principal's physical or mental health, including medical and hospital records;
- Execute a release required to obtain the information; and
- Consent to the disclosure of the information. *§166.157*

To what extent is an agent liable for a decision made under the authority of a medical power of attorney?

An agent, acting in good faith, will not incur criminal or civil liability for a health care decision made under a medical power of attorney. *§166.160(a)*

What liability does a physician or provider incur as a result of a decision made by an agent under a medical power of attorney?

The principal's attending physician or providers will not be subject to civil or criminal liability, or disciplinary action if any act or omission is performed in good faith under the direction of an agent who has a medical power of attorney, provided the act or omission does not constitute a failure to exercise due care in the provision of health care services. *§166.160(b)*

Who is liable for the cost of medical care decisions made by the agent?

The agent will not be responsible for the cost consequent to the agent's decision if the principal, if competent, would not have been liable for the costs connected with making the same decision as the agent. *§166.161*

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Medical Power of Attorney Disclosure Statement Form

This is an important legal document. Before signing this document, you should know these important facts:

Unless you state otherwise, this document gives the person you name as your agent the authority to make all health care decisions for you in accordance with your wishes, when your doctor certifies that you lack the capacity to make health care decisions. 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.

It is important that you discuss this document with your physician or provider before you sign it to ensure 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 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's advice.

The person you appoint as agent should be someone when you know and trust and who is 18 years of age or older, or is under 18 years of age and has had the disabilities of minority removed. If you appoint a 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 physician or 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; give each a signed copy; and indicate on the document 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. In such case, 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 physician or 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.

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:

(1)You sign it and have your signature acknowledged before a notary public, or
(2)You sign it 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 Form

Designation of Health Care Agent

I, (insert your name) _____appoint:

Name: _____ Phone: _____

Address: _____

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 my physician certifies this fact in writing.

LIMITATIONS ON THE DECISIONMAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

_____

(continued on back)

Medical Power of Attorney Form *Designation of Health Care Agent (continued)*

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:

First Alternate Agent

Name: _____ Phone: _____

Address: _____

Second Alternate Agent

Name: _____ Phone: _____

Address: _____

The original of this document is kept at _____

The following individuals or institutions have signed copies:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

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. You may sign it and have your signature acknowledged before a notary public, or you may sign it in the presence of two competent adult witnesses.

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____ day of _____month_____ year at _____

City and State: _____ Date: _____

Signature: _____ Print Name: _____

State of Texas, County of _____.

This instrument was acknowledged before me on_____ (date) by_____ (name of person acknowledging).

_____

NOTARY PUBLIC, State of Texas

Notary's printed name:_____ My commission expires: _____

OR

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this medical power of attorney on _____ day of _____month_____ year at _____

City and State: _____ Date: _____

Signature: _____ Print Name: _____

I am not the person appointed an 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: _____

Address: _____ Date: _____

SIGNATURE OF SECOND WITNESS _____

Signature: _____ Print Name: _____

Address: _____ Date: _____

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Print Form

STOP DO NOT RESUSCITATE

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____. The above noted person personally appeared before me and signed the above noted declaration on this date: _____.

Signature & seal: _____ Notary's printed name: _____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.
APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.
IMPLEMENTATION: A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:
Section A - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.
Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.
Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.
Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.
Section E - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.
Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is not a representative of the ethics or medical committee of the health care facility in which the person is a patient.
In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.
REVOCATION: An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.
AUTOMATIC REVOCATION: An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS

Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state**.** [HSC §166.002(12)].
Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]
Qualified Relative: A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.
Qualified Witnesses: Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.
Report problems with this form to the Texas Department of State Health Services (DSHS) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC §166.011

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Advance Directives Act (see §166.033, Health and Safety Code)

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 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.

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 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 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.)

_____

_____

_____

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. _____

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 _____

City, County, State of Residence _____

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 _____ Witness 2 _____

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.

DECLARATION FOR MENTAL HEALTH TREATMENT

I, _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court that my ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, is impaired to such an extent that I lack the capacity to make mental health treatment decisions. "Mental health treatment" means electroconvulsive or other convulsive treatment, treatment of mental illness with psychoactive medication, and preferences regarding emergency mental health treatment.

(OPTIONAL PARAGRAPH) I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

_____

_____

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychoactive medications are as follows:

☐ I consent to the administration of the following medications:

_____

☐ I do not consent to the administration of the following medications:

_____

☐ I consent to the administration of a federal Food and Drug Administration approved medication that was only approved and in existence after my declaration and that is considered in the same class of psychoactive medications as stated below:

_____

_____

Conditions or limitations:_____

_____

_____

CONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding convulsive treatment are as follows:

☐ I consent to the administration of convulsive treatment.

☐ I do not consent to the administration of convulsive treatment.

Conditions or limitations:_____

_____

_____

PREFERENCES FOR EMERGENCY TREATMENT

In an emergency, I prefer the following treatment FIRST (circle one):
Restraint Seclusion Medication

In an emergency, I prefer the following treatment SECOND (circle one):
Restraint Seclusion Medication

In an emergency, I prefer the following treatment THIRD (circle one):
Restraint Seclusion Medication

_____I prefer a male/female to administer restraint, seclusion, and/or medications.

Options for treatment prior to use of restraint, seclusion, and/or medications:

_____

_____

Conditions or limitations:_____

_____

ADDITIONAL PREFERENCES OR INSTRUCTIONS

_____

_____

Conditions or limitations: _____

_____

Signature of Principal: _____ Date: _____

SIGNATURE ACKNOWLEDGED BEFORE NOTARY PUBLIC

State of Texas

County of_____

This instrument was acknowledged before me on _____(date) by _____(name of notary public).

_____
NOTARY PUBLIC, State of Texas

Printed name of Notary Public:

_____

My commission expires:_____

SIGNATURE IN PRESENCE OF TWO WITNESSES

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal's name has been represented to me by the principal, that the principal signed or acknowledged this declaration 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, and that I am not a provider of health or residential care to the principal, an employee of a provider of health or residential care to the principal, an operator of a community health care facility providing care to the principal, or an employee of an operator of a community health care facility providing care to the principal.

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 and do not have a claim against 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: _____

NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment. The instructions that you include in this declaration will be followed only if a court believes that you are incapacitated to make treatment decisions. Otherwise, you will be considered able to give or withhold consent for the treatments.

This document will continue in effect for a period of three years unless you become incapacitated to participate in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapacitated.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapacitated. YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED BY A COURT TO BE INCAPACITATED. A revocation is effective when it is communicated to your attending physician or other health care provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration is not valid unless it is either acknowledged before a notary public or signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.