



# Advance Directives: Informed Choices About Your Health Care

## To Our Patients:

As a general rule, you are entitled to decide what medical treatments you will receive. Your physician will inform you of the risks and benefits of proposed treatments, and any alternative forms of treatment that you should consider.

On admission, you are asked to review and sign a general consent to admission and treatment. In some instances, such as surgery, you will be asked to sign a specific form indicating that you have been advised by your physician concerning your options and that you consent to treatment. In instances involving relatively simple procedures, you do not need to sign a separate consent form, but you should understand and agree with the treatment before it is rendered. Normally, no treatment can be done without your permission. (There are exceptions, such as life threatening emergencies, when it can be assumed that you want to be treated unless you have made other instructions.)

The general rules—that you decide what treatment you receive, and that the hospital and your physician will provide all treatment necessary to treat disease or injury, to extend life and to prevent suffering—remain true no matter how ill you may become.

## Advance Directives

Sometimes, when patients are terminally ill, they must decide how much treatment they want to receive. At some point, they may prefer only to be made as comfortable as possible. Or, they may wish that all efforts be made to extend their life, or that certain treatments be tried, but not others.

What happens if you can't tell us what you want us to do, or if you become so sick you can't make important decisions? Your doctor will consult with your family and try to determine what your wishes would be.

How can you be sure your family and your doctor will know what you want? Texas law provides two ways to do this.

One way you can be sure to receive the treatment you would want is to sign a Medical Power of Attorney. There is a required legal form for this. A copy of this form, with specific information on how to use it, is enclosed. With a Durable Power of Attorney, you can designate an agent—usually a close relative or friend—who will make decisions about your treatment in the event your illness becomes so serious that your doctor determines that you are no longer capable of making decisions. If you decide to use this form, you should choose someone you trust, and be sure the person understands your feelings about medical treatment.

The other way you can make your wishes known in a legally binding way is called a Directive to Physicians, sometimes referred to as a Living Will. With a Directive to Physicians, you can tell your doctor, and our staff, what treatments you want or don't want in the event your illness reaches the point that you are considered to be terminally ill. It is especially important to consult with your doctor in writing a Directive to Physicians, as your doctor can best advise you about the kinds of treatment likely to be proposed for you.

If you have already signed a Directive to Physicians, or if you execute a new one, be sure to tell your doctor and have the document included in your medical records at your doctor's office.

## Limitations

There are limits on Directives to Physicians and on Medical Powers of Attorney. Read the materials carefully before executing either.

## Minors

If you are under 18, your rights under these laws are limited. Your parent, legal guardian, or adult spouse can execute a Directive to Physicians for you. If you are under 18, you may only execute a Medical Power of Attorney if you are married, if you are in the military services, or if you have been given the legal status of an adult in some other way, such as by a court order.

## Other Documents

Under Texas law, a Medical Power of Attorney or Directive to Physicians that was executed in another state is valid if it was valid in the state where it was executed. If you have signed such a document, you should inform your physician. If possible, a new form should also be signed, to avoid any doubt about the validity of the document from out of state.

Texas law also provides for a Declaration for Mental Health Treatment. If you have executed such a document, you may present it to us and it will be placed on your chart. Its directives will be honored by MHS's staff.

You do not have to sign a Directive or a Power of Attorney. There is no requirement to do so, and you should only use one if you believe it will help ensure that your wishes are understood and carried out.

## If You Need Further Help or Information

This information is provided by Methodist Health System as an explanation of hospital policy, and in compliance with the laws requiring that we inform you of your options. If you need further information you may ask your nurse or physician, the hospital's Social Work Department, the Hospital Chaplain, your personal attorney, or spiritual advisor.

## **Notice To Person Making a Declaration For Mental Health Treatment**

Chapter 137, Title 6, Civil Practice and Remedies Code

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 signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

## 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:

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### 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:

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\_\_\_\_\_ I do not consent to the administration of the following medications:

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\_\_\_\_\_ 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:

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Conditions or limitations: \_\_\_\_\_

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### 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: \_\_\_\_\_

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### 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:

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Conditions or limitations: \_\_\_\_\_

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### Additional Preferences or Instructions

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Conditions or limitations: \_\_\_\_\_

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Signature of Principal/Date: \_\_\_\_\_

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## 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: \_\_\_\_\_



# MEDICAL POWER OF ATTORNEY

## DESIGNATION OF HEALTH CARE AGENT

I, \_\_\_\_\_ (insert your name) 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 designate agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation automatically is 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  
\_\_\_\_\_ (month) \_\_\_\_\_ (year) 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: \_\_\_\_\_

## 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 usually are 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 also may wish to complete a directive related to the donation of organs and tissues.

### DIRECTIVE

I, \_\_\_\_\_ (insert your name), 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 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 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 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 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:**

- **"Artificial 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 stomach (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 himself/herself; 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 people in your life.

- **"Life-sustaining treatment"** means 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 artificial hydration and nutrition. 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 people in your life.

## INFORMATION CONCERNING THE MEDICAL POWER OF ATTORNEY

### **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 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.

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 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 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 IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING MAY NOT ACT AS ONE OF THE WITNESSES:**

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) 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;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) 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 office, director, partner or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.