

DIGNITY EXTENSIVISTS OF CENTRAL TEXAS

Texas Advance Health Care Directive

Compliant with Texas Health and Safety Code § 166.031 to § 166.053

1 DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES (LIVING WILL)

1 DECLARATION

I, _____ [Name of Patient], declare that if at any time I should have an incurable condition caused by injury, disease, or illness certified to be a terminal or irreversible condition by my attending physician, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

2 TERMINAL CONDITION INSTRUCTIONS

A "terminal condition" is 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.

Select ONE option:

- ☐ **OPTION A:** I request that all life-sustaining treatment be withheld or withdrawn if I have a terminal condition.
- ☐ **OPTION B:** I request that life-sustaining treatment be provided to prolong my life as long as possible if I have a terminal condition.

3 IRREVERSIBLE CONDITION INSTRUCTIONS

An "irreversible condition" is a condition, injury, or illness that may be treated, but is never cured or eliminated; that leaves a person unable to care for or make decisions for the person's own self; and that, without life-sustaining treatment, is fatal.

Select ONE option:

- ☐ **OPTION A:** I request that all life-sustaining treatment be withheld or withdrawn if I have an irreversible condition.
- ☐ **OPTION B:** I request that life-sustaining treatment be provided to prolong my life as long as possible if I have an irreversible condition.

4 ADDITIONAL GOALS OF CARE & INSTRUCTIONS (OPTIONAL)

2 TEXAS MEDICAL POWER OF ATTORNEY (MPOA)

2.1 DESIGNATION OF HEALTH CARE AGENT

I appoint the following individual as my health care agent to make any and all health care decisions for me when I am no longer capable of making them myself:

Primary Agent Name _____

Relationship _____ Phone _____

Address _____

Alternate Agent Name (Optional) _____

Relationship _____ Phone _____

2.2 AGENT'S POWERS & TEXAS LEGAL LIMITATIONS

My agent is authorized to make health care decisions on my behalf in accordance with this document. Under Texas Health and Safety Code § 166.152, my agent CANNOT consent to inpatient mental health services, convulsive treatment, psychosurgery, or abortion.

3 EXECUTION & LEGAL VALIDATION (TEXAS MANDATE)

This document **MUST** be executed in the presence of **TWO (2) qualified adult witnesses** OR acknowledged before a **Notary Public**.

DECLARANT / PATIENT

Declarant / Patient Signature _____ Date _____

Printed Name _____

OPTION A: TWO QUALIFIED WITNESSES STATEMENT

Witness Requirements under Texas Law: At least one witness must NOT be related to you by blood or marriage, entitled to any part of your estate, designated as your agent, your attending physician, or an employee of your healthcare provider/facility.

Witness 1 Signature _____ Date _____

Printed Name _____

Witness 2 Signature _____ Date _____

Printed Name _____

OR

OPTION B: NOTARY PUBLIC ACKNOWLEDGMENT

State of Texas, County of _____

This instrument was acknowledged before me on this _____ day of _____, 20____, by
_____ [Name of Declarant].

Notary Public, State of Texas _____ (Notary Seal) _____