Date document witnessed **OR** notarized\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction**

This Advance Health Care Directive allows you to share your values, your choices, and your instructions about your future health care. It is important to have conversations about your goals, values and health care preferences with your agent and family **BEFORE** signing this directive. This form may be used to:

* Name someone you trust to make health care decisions for you (your health care agent), **OR**
* Provide written instructions about your future health care, **OR**
* **Both,** name a health care agent **AND** provide written instructions for future health care.

**Part 1 allows you to name a health care agent.**

**Part 2 gives you an opportunity to share your values and what is important to you.**

**Part 3 allows you to give written instructions about your future health care.**

**Part 4 allows you to guide your agent’s decision making by stating your wishes and preferences.**

**Part 5 allow you to make your Advance Health Care Directive legally valid in the State of Texas.**

**Part 6 prepares you to share your wishes and this document with others.**

You are free to modify this form or use a different form.

**This Advance Health Care Directive will replace any Advance Health Care Directive you have completed in the past. In the future, if you want to cancel or change your named agent, you must do so in writing and sign that document, or by personally telling your doctor. The best way to prevent any confusion is to complete a new Advance Health Care Directive.**

Full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST MIDDLE LAST

Date of Birth\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 1: Power of Attorney for Health Care - Selecting My Health Care Agent**

***DISCLOSURE STATEMENT***

**TEXAS MEDICAL POWER OF ATTORNEY**

**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 you wishes, including your religious and moral beliefs, when you are no longer capable of making them for 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 my 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 and/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 your 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 you 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 the 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 you objection. You have the right to revoke the authority granted to you 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 you agent. Any alternate agent you designate has the same authority to make health care decisions for you.

SIGN BELOW TO ACKNOWLEDGE YOUR RECEIPT OF THIS DISCLOSURE STATEMENT PRIOR TO YOUR EXECUTION OF THE MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AND TO AFFIRM THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED THEREIN.

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form **does not** give my health care agent the authority to make financial or other business decisions. My health care agent **does not** have the power to place me a mental health treatment facility.

**My Texas Medical Power of Attorney (Agent):**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to me\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**First alternate health care agent is:**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to me\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Second alternate health care agent is:**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to me\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I *DO NOT* have a health care agent:**

\_\_\_\_\_\_\_\_ I do not have a health care agent. This document represents my values and preferences and is to be used to instruct my treating physician and medical staff.

**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 leaved 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 you 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 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.

**I authorize my health care agent to do the following:   
 *Initial the powers you would like to give your agent and draw a line through the items you do not want.***

\_\_\_\_\_\_\_\_ Make choices for me about my health care. This includes decisions about tests, medicine, and surgery. It also includes decisions to provide, not provide, or stop all forms of health care to keep me alive, including artificial nutrition (food) and hydration (water). If treatment has already been started, my health care agent can keep it going or have it stopped depending upon my stated instructions and my best interests.

\_\_\_\_\_\_\_\_ Interpret any instructions I have given in this form or given in other discussions according to my health care agent’s understanding of my values and preferences.

\_\_\_\_\_\_\_\_ Review and release my medical records as needed to make decisions.

\_\_\_\_\_\_\_\_ Arrange for my medical care and treatment in Texas or another state, as my health care agent thinks appropriate.

\_\_\_\_\_\_\_\_ Choose physicians, health care providers, and organizations to provide my medical treatment.

\_\_\_\_\_\_\_\_ Arrange for care in a nursing home or community-based residential care facility for a long-term stay.

\_\_\_\_\_\_\_\_ Make decisions about organ-tissue or body donation after my death.

\_\_\_\_\_\_\_\_ Arrange for and make decisions about the care of my body after death (including autopsy).

**Please provide any additional comments or restrictions to the previous section. (For example, you may name people you would or would not want to be involved in decisions on your behalf. You may also specify additional decisions you would not want your agent to make.) Attach additional page(s) if necessary. Be clear and double check that there are no contradictions so as to eliminate confusion.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **Additional powers of my health care agent**

***Initial the line or lines below, if you want your agent to have any of the following additional powers.***

\_\_\_\_\_\_\_\_ I want my agent to immediately begin making health care decisions for me even if I am able to decide or speak for myself.

\_\_\_\_\_\_\_\_ I want my agent to continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership has been completed.

**Part 2: My Values (OPTIONAL) Cross out and initial, this page and the next, if you choose not to   
 complete.**

***I want my agent and loved ones to know what matters most to me, so that they can make decisions about my health care and match who I am and what is important to me. To give you a sense of what matters most to me, I’d like to tell you some things about myself, such as how I enjoy spending my time, who I like to be with, and what I like to do. I’d also like to tell you about the circumstances that would make life no longer worthwhile for me.***

1. If the extension of my life would result in mere biological existence, devoid of cognitive function, with no reasonable hope for normal functioning, then I do not desire any form of life-sustaining procedure, including nutrition and hydration.

**Please circle if you: AGREE OR DISAGREE with the statement above**

1. If I were having a really good day, I would be doing the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What matters most to me:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Quality of life means more than the length of my life. Life would no longer be worth living if I were **not** able to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 2 Continued**

5. My thoughts and feelings about where I would prefer to die:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. I want my loved ones to know that if I am nearing my death, I would appreciate the following for comfort and support (prayers, readings, rituals, music, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Religious or spiritual affiliation:

I am of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_faith/spiritual tradition, and am a member of (faith/spiritual   
  
community) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in (city)   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I would like my faith/spiritual community notified if I am seriously ill or dying. I would like to include in my memorial service, if possible, the following (people, music, rituals, readings, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 3: My Health Care Instructions**

***If I become unable to communicate or make my own choices, I ask that my health care agent represent my choices as detailed below, and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are unable to make decisions on my behalf, this document represents my wishes.***

Note: If you choose not to provide written instructions, your health care agent will make decisions based on your spoken or personally communicated directions. If your directions are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values and goals.

1. **Treatments to prolong life, consider the following situation.**  
    You have a sudden accident or stroke.

Doctors have determined you have a brain injury, leaving you unable to recognize yourself or your loved ones. The doctors have told your health care agent and/or family that you are not expected to recover these abilities. Life-sustaining treatments \*are required to keep you alive.

***In this situation what would you want?***

* I would want to **STOP** life-sustaining treatment. I realize this would probably lead me to die sooner than if I were to continue treatment.

**CHOOSE**

**ONE**

* I would want to continue life-sustaining treatment **ONLY** for the purpose of organ or tissue donation.
* I would want to continue life-sustaining treatment.

*Please provide any additional instructions about life-sustaining treatments.* ***For example****, you may want to state a specific time period that you would want to be kept alive if there were no improvement to your health. If life-sustaining treatment has been started, you may wish for treatment to continue until loved ones can arrive.*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **CPR (Cardiopulmonary resuscitation)**

***If your heartbeat and/or breathing stop, CPR can be done to try to revive you. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.***

*You have a choice about CPR, it can save lives. CPR works best if done quickly, within a few minutes, on a* ***healthy*** *adult. While CPR may restart the heart, it rarely returns even those who are otherwise healthy to their previous state of health. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen. The success rate of CPR is very low for those with illnesses that require hospital care, or are elderly and frail.*

**Research shows that if you are in a hospital and get CPR, you have a 17 percent chance of the procedure being successful and leaving the hospital alive. *Peberdy MA, Kaye W, Ornato JP, et al. Cardiopulmonary resuscitation in adults in the hospital: A report of 14,720 cardiac arrests from the National Registry of Cardiopulmonary Resuscitation. Resuscitation- 2003; 58 297-308.***

If you are certain you do not want CPR, please discuss completing a Medical Order for Scope Treatment (**MOST**) or, an Out of Hospital Do Not Resuscitate (**OH-DNR**) with you physician or a qualified health care provider.

*\*If you would like additional information about CPR, please speak to your doctor or qualified health care provider.*

**In the event that your heart and breathing stop, what would you want?**

* I always want CPR attempted.

**CHOOSE**

**ONE**

* I never want CPR attempted, but rather, want to allow a natural death
* I want CPR attempted unless the doctor treating me determines any of the following:  
  + I have an incurable illness or injury and am likely to die within a short period of time; or
  + I have no reasonable chance of survival if my heart or breathing stops; or
  + I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause significant suffering; or
  + I have little chance of returning to a quality of life I have discussed with my health care agent.

**Part 4: Wishes and Preferences (Cross out and initial if you choose not to complete**.)  
 **1. ORGAN DONATION**

***Becoming an organ and tissue donor when you die can save lives and improve the quality of life for others. Make sure this has been shared with family and your agent. Below are some choices for you to consider. Choose one by initialing in the box.***

**Upon my death:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I want to donate any needed organs or tissues  \_\_\_\_\_\_\_\_\_\_ Initial Here | **OR** | I want to donate the following organs or tissues only  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Organs  \_\_\_\_\_\_\_\_\_\_ Initial Here | **OR** | I do not want to donate any of my organs or tissues, and I do not want my health care agent to authorize donation on my behalf.  \_\_\_\_\_\_\_\_\_\_ Initial Here |

**2. I want to donate my whole body after death for research. AS REQUIRED, I have made arrangements in advance**  
 Organization/Institution Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Upon my death I would like to be (choose one)**

**\_\_\_\_\_\_\_\_ Cremated \_\_\_\_\_\_\_\_ Buried \_\_\_\_\_\_\_\_ I don’t have a preference**

I have already made the following arrangements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Other preferences/instructions**:   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 5: Making This Document Legally Valid**

**To make your Advance Health Care Directive legally valid in Texas it must be signed by**

**Two witnesses *OR* acknowledged before a Notary Public.   
Follow the steps outlined below:**

**Statement of Witnesses**

* I declare under penalty of perjury under the laws of Texas
* that the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or that the individual’s identity was proven to me by convincing evidence,
* that the individual signed or acknowledged this Advance Health Care Directive in my presence,
* that the individual appears to be of sound mind and under no duress, fraud, or undue influence,
* that I am at least 18 years old and not appointed as an agent by this Advance Health Care Directive, and

**ADDITIONAL STATEMENT OF WITNESS:** At least one of the witnesses must meet the following requirements and sign the following declaration:

I further declare under penalty of perjury under the laws of Texas that I am not related to the individual executing this Advance Health Care Directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual’s estate upon his or her death under a will now existing or by operation of law. I am not a person designated by the individual to make a health care or treatment decision. I am not the individual’s health care provider, an employee of the individual’s health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, or an employee of an operator of a residential care facility for the elderly. I am not an officer, director, partner, or business office employee of a health care facility in which the individual is being cared for or of any parent organization of the health care facility.

**WITNESS Number One:**

Print full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WITNESS Number Two:**  
Print full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MY SIGNATURE: Must be in the presence of both witnesses OR notary public**

**I ask that my family, my doctors, and other health care providers, my friends and all others, follow my instructions as communicated by my health care agent or otherwise expressed in this form. I agree with everything that is written in this document and I have made this document willingly.**

**If my designated health care agent is not available, or if I have not designated a health care agent, I understand that a spokesperson will be chosen for me following rules set out 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. The directive will remain in effect until I revoke it. No other person may do so.**

My name printed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTARY PUBLIC**

SUBSCRIBED AND ACKNOWLEDGED BEFORE ME by the said Declarant, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and by the said Witnesses, (Witness 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and (Witness 2), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on this the \_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Notary Seal:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Notary Public, State of Texas

**Part 6: Next Steps**  
***Now that you have completed your Advance Health Care Directive, you should also take the following steps.***

**DISCUSS**

* **Review** your health care wishes with the person(s) you have asked to be your agent (if you haven’t already done so). Make sure he or she feels able to perform this important job for you in the future.
* **Talk** to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.

**GIVE COPIES**

* Give your health care agent(s) a copy of your Advance Health Care Directive.
* Give a copy of your Advance Health Care Directive to you doctor and Midland Memorial Hospital medical Records Department.
* Give a copy to your attorney (optional)
* Make a copy for yourself and keep it at home with the original where both can be easily found.

**TAKE IT WITH YOU**

* If you go to the hospital or nursing home, take a copy of your Advance Health Dare Directive and ask that it be placed in you medical record.
* Take a copy with you any time you will be away from home for an extended period of time.

**REVIEW REGULARLY**

Review your health care wishes whenever any of the “**Five D’s**” occur:

* + **Decade** when you start each new decade of your life.
  + **Death**  whenever you experience the death of a loved one.
  + **Divorce** when you experience a divorce or other major family change.
  + **Diagnosis** when you are diagnosed with a serious health condition.
  + **Decline** when you experience a significant decline or deterioration of an existing health  
     condition, especially when you are unable to live on you own.

If your wishes change, complete a new Advance Health Care Directive and tell your agent(s), family, and health care provider. Provide them with new copies. **A properly signed Advance Directive with the most recent date is the one that is legally valid.**

**Copies of this document have been given to:**

**Primary (Main) Health Care Agent**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alternate Health Care Agent #1**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alternate Health Care Agent #2**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family/Friends**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Care Provider-Clinic**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Others:**

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorney (Optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Should you have any questions or concerns, please contact:**

|  |  |
| --- | --- |
| **Advance Care Plan Coordinator**  Office: 432-221-4212 | **Assistant Advance Care Plan Coordinator** Office: 432-221-2036 |
| **BeginTheConversation@midland-memorial.com** | |

**FOR USE BY MIDLAND MEMORIAL HOSPITAL ONLY**

This section will be completed when a completed form is presented by a patient being admitted to Midland Memorial Hospital, Midland, TX 79701.

|  |  |  |  |
| --- | --- | --- | --- |
| (Patient Label) | | Advance Directive | |
|  | | Patient Access | |
| Patient Name: |  | CH# 001641 | Page 15 of 15 |
| Patient DOB: |  | Effective Date: 08/08/2016 | |
| MR #: |  | Last Review Date: 08/08/2016 | |
| Acct #: |  | Scan to: Advance Directives | |