DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

I,	, recognize that the best health care is based		
	ership 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 followin	g treatment preferences be honored:		
die within si	gment of my physician, I am suffering with <u>a terminal condition</u> from which I am expected to x months, even with available life-sustaining treatment provided in accordance with andards 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.)		
myself or m	gment of my physician, I am suffering with <u>an irreversible condition</u> so that I cannot care for ake decisions for myself and am expected to die without life-sustaining treatment provided in with prevailing standards of care:		
	I request that all treatments other than those needed to keep me comfortable be		
	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.)		
	CIRCL.)		
Additional requests: (After discussion with your physician and/or family members, you may wish to consider checking specific requests in this space that you do or do not want if you have a terminal or irreversible condition and can no longer communicate your wishes). Initial the statements that match what you would desire. If you do not initial a statement, then you are leaving your medical power of attorney to decide. There is room to make additional requests at the end of this document.) Only initialed statements are endorsed and indicate my desires. Statements made in this section override those made in the prior section.			
	I request that if my heart should stop beating and my lungs should stop breathing		
	that no efforts at resuscitation should be made		
	OR		
	I request that if my heart should stop beating and my lungs should stop breathing that all resuscitation efforts should be made.		
	I request that if clinically appropriate and offered by my physician, artificial		
	nutrition and hydration be withheld or removed		
	OR		
	I request that if clinically appropriate and offered by my physician, artificial nutrition and hydration always be given.		
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I request that if clinically appropriate and offered by my physician, intravantibiotics be withheld or removed OR	
I request that if clinically appropriate and offered by my physician, intravantibiotics be given.	enous
I request that if clinically appropriate and offered by my physician, dialys withheld or removed OR	
I request that if clinically appropriate and offered by my physician, dialys given.	is be
I request that if clinically appropriate and offered by my physician, blood products be withheld or removed OR	and blood
I request that if clinically appropriate and offered by my physician, blood products be given.	and blood
I request that if clinically appropriate and offered by my physician, respir support should be withheld or withdrawn OR	atory
I request that if clinically appropriate and offered by my physician, respir support should be given.	atory
If there is a clinical experiment which has a chance of benefiting me, there decision maker permission to consent for my participation OR	I give my
If there is a clinical experiment, which has no chance of benefiting me, the my decision maker permission to consent for my participation.	en I give
I request that if clinically appropriate and offered by my physician, surge intended to prolong my life (as opposed to be palliative or provide comfo not be done OR	•
I request that if clinically appropriate and offered by my physician, surge intended to prolong my life (as opposed to be palliative or provide comfo be done.	•
Quality of life is more important to me than quantity OR	
Quantity of life is more important to me than quality.	
I wish to be free from pain even if it shortens my life.	

Other requests:	
	representative or I elect hospice care, I understand and agree that only ne comfortable would be provided and I would not be given available
If I have not designated a medica me following standards specified	power of attorney, I understand that a spokesperson will be chosen for in the laws of Texas.
even with the use of standard of care, I a	f my physician, my death is imminent within minutes to hours, all available medical treatment provided within the prevailing eknowledge that all treatments may be withheld or removed to maintain my comfort. (applies only if initialed)
If, in the judgment of even with the use of	f my physician, my death is imminent within minutes to hours, all available medical treatment provided within the prevailing ill wish that all efforts be made to sustain my life (applies only
directive will remain in effect un	this directive has no effect if I have been diagnosed as pregnant. This il I revoke it. No other person may do so.
City, County, State of Residence	
witness designated as Witness 1: patient and may not be related to part of the estate and may not has attending physician or an employ care facility in which the patient patient care to the patient. This w	nust sign below, acknowledging the signature of the declarant. The may not be a person designated to make a treatment decision for the the patient by blood or marriage. This witness may not be entitled to any the a claim against the estate of the patient. This witness may not be the eet of the attending physician. If this witness is an employee of a health is being cared for, this witness may not be involved in providing direct itness may not be an officer, director, partner, or business office in which the patient is being cared for or of any parent organization of
WITNESS 1:Print Name	
Print Name	Signature
WITNESS 2: Print Name	Signature