THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: SEX: FC:

Directive To Physicians and Family Or Surrogates (Living Will)

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, goals and beliefs. 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 care 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 to better assure that the Directive reflects your most current 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 advisors. You may also wish to complete a Directive related to the donation of organs and tissues.

See Definitions with explanations on page 5.

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 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.)

Initials: _____ Date/Time:_____

PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: SEX: FC:

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.)

_____

_____

_____

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 treatment decisions with my physician compatible with my personal values:

1. _____

2. _____

(If a *Medical Power of Attorney* has been executed, then an agent has already been named and you should not list additional names above 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.

Initials: _____ Date/Time:_____

(YOU MUST DATE AND SIGN THIS LIVING WILL. YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES OR YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

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

Signature: _____

Print Name: _____

Address: _____ Date: _____

WITNESS 2

Signature: _____

Print Name: _____

Address: _____ Date: _____

Initials: _____ Date/Time: _____

PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: SEX: FC:

OR
SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this Living Will on _____ day of

_____, _____, at _____, _____.
(month) (year) (city) (state)

_____
(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: _____

Initials: _____ Date/Time:_____

PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: SEX: FC:

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 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 a major organ (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 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 persons in your life.

Initials: _____ Date/Time:_____