

**TEXAS**  
**Advance Directive**  
**Planning for Important Healthcare Decisions**

***Caring Connections***  
*1731 King St., Suite 100, Alexandria, VA 22314*  
[www.caringinfo.org](http://www.caringinfo.org)  
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

**It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

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## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the state-specific contacts for Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives, located in Appendix B.

## INTRODUCTION TO YOUR TEXAS ADVANCE DIRECTIVE

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Texas Medical Power of Attorney** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. Your attending physician must certify in writing that you are unable to make healthcare decisions and file the certification in your medical record. The Medical Power of Attorney is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

2. The **Texas Directive to Physicians and Family or Surrogates** is your state's living will. It lets you state your wishes about medical care in the event that you develop a terminal or irreversible condition and can no longer make your own medical decisions. The Directive becomes effective when your attending physician certifies in writing that you have a terminal or irreversible condition.

*Note: These documents will be legally binding only if the person completing them is a competent adult, 18 years or older or a person under 18 years of age who has had the disabilities of minority removed.*

## COMPLETING YOUR TEXAS MEDICAL POWER OF ATTORNEY

### Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (An agent may also be called an “attorney-in-fact” or “proxy.”)

The person you appoint as your agent **cannot** be:

- your doctor or other treating healthcare provider,
- an employee of your treating healthcare provider, unless he or she is related to you,
- your residential care provider, or
- an employee of your residential care provider, unless he or she is related to you.

You can appoint a second and third person as your alternate agent. The alternate will step in if the first person you name as agent is unable, unwilling or unavailable to act for you.

### How do I make my Texas Medical Power of Attorney legal?

The law requires that you sign your Medical Power of Attorney, or direct another to sign it, in the presence of two witnesses, who must also sign the document.

At least one witness **cannot** be:

- the person you name as your agent,
- related to you by blood or marriage,
- your doctor or an employee of your doctor,
- an employee of a healthcare facility in which you are a patient (if he or she is involved in your care),
- an officer, director, partner, or business office employee of the healthcare facility or of any parent organization of the healthcare facility,
- a person entitled to any part of your estate upon your death either by will or operation of law, or
- any other person who has a claim against your estate at the time you sign the Medical Power of Attorney.

*Note: You do not need to notarize your Texas Medical Power of Attorney.*

## **COMPLETING YOUR TEXAS MEDICAL POWER OF ATTORNEY (CONTINUED)**

### **Should I add personal instructions to my Texas Medical Power of Attorney?**

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical condition changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest.

Talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use your Texas Directive to Physicians and Family or Surrogates.

### **What if I change my mind?**

You may revoke your Texas Medical Power of Attorney at any time by:

- notifying your agent, doctor or residential care provider of your revocation (this may be done orally, in writing or by any other act which demonstrates your intent to revoke your agent's power); or
- executing another medical power of attorney.

If you appoint your spouse as your agent, and your marriage is dissolved or annulled, your agent's authority is automatically revoked, unless your Texas Medical Power of Attorney provides otherwise.

## COMPLETING YOUR TEXAS DIRECTIVE

### How do I make my Texas Directive legal?

In order to make your Directive legally binding, you must sign it, or direct another to sign it, in the presence of two witnesses who must also sign the document. At least one witness **cannot** be:

- designated by you to make a treatment decision,
- related to you by blood or marriage,
- entitled to any part of your estate after your death under a will or by operation of law,
- your doctor or an employee of your doctor,
- an employee of a healthcare facility in which you are a patient, if he or she is directly involved in your care,
- an officer, director, partner, or business office employee of the healthcare facility or of any parent organization of the healthcare facility, or
- a person who, at the time you sign the Directive, has a claim against your estate after your death.

*Note: You do not need to notarize your Texas Directive to Physicians.*

### Can I add personal instructions to my Directive?

Yes. You can add personal instructions, including listing particular treatments and making an organ donation, in the part of the document called "Additional Requests."

If you have appointed an agent through a medical power of attorney, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Directive are to be decided by my agent."

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor for more information.

## COMPLETING YOUR TEXAS DIRECTIVE (CONTINUED)

### **What if I change my mind?**

You may revoke your Texas Directive at any time by:

- canceling, defacing, obliterating, burning, tearing or otherwise destroying the directive,
- signing and dating a written revocation, or
- orally stating your intent to revoke the directive.

You or someone acting on your behalf must notify your doctor of the revocation.

### **What other important facts should I know?**

A pregnant patient's Texas Directive will not be honored due to restrictions in the state law.

**TEXAS MEDICAL POWER OF ATTORNEY**  
**PAGE 1 OF 6**

**Disclosure Statement for 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 healthcare 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 "healthcare" 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 healthcare 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 healthcare 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 healthcare as you would have had.

It is important that you discuss this document with your physician or other healthcare 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 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 healthcare 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 healthcare decisions made in good faith on your behalf.

## TEXAS MEDICAL POWER OF ATTORNEY – PAGE 2 OF 6

Even after you have signed this document, you have the right to make healthcare 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 healthcare decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS 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 your healthcare facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the healthcare facility or of any parent organization of the healthcare 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.

INSTRUCTIONS

TEXAS MEDICAL POWER OF ATTORNEY – PAGE 3 OF 6

TEXAS MEDICAL POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT.

PRINT YOUR  
NAME

I, \_\_\_\_\_, appoint:  
(name)

PRINT THE NAME,  
ADDRESS AND  
HOME AND WORK  
TELEPHONE  
NUMBERS OF YOUR  
AGENT

\_\_\_\_\_  
(name of agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(work telephone number) (home telephone number)

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.

STATE  
LIMITATIONS ON  
YOUR AGENT'S  
POWER  
(IF ANY)

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT  
ARE AS FOLLOWS:

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PRINT THE NAME,  
ADDRESS AND  
HOME AND WORK  
TELEPHONE  
NUMBERS OF YOUR  
FIRST AND  
SECOND  
ALTERNATE  
AGENTS

FIRST  
ALTERNATE

SECOND  
ALTERNATE

LOCATION OF  
ORIGINAL

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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 designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically 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 of first alternate agent)

\_\_\_\_\_  
(home address)

\_\_\_\_\_  
(work telephone number)

\_\_\_\_\_  
(home telephone number)

B. Second Alternate Agent

\_\_\_\_\_  
(name of second alternate agent)

\_\_\_\_\_  
(home address)

\_\_\_\_\_  
(work telephone number)

\_\_\_\_\_  
(home telephone number)

The original of this document is kept at: \_\_\_\_\_  
\_\_\_\_\_

**TEXAS MEDICAL POWER OF ATTORNEY — PAGE 5 OF 6**

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 understood 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 \_\_\_\_\_  
(date)

day of \_\_\_\_\_, at \_\_\_\_\_.  
(month) (year) (city and state)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(print name)

LOCATION OF COPIES

EXPIRATION DATE (IF ANY)

PRINT THE DATE PRINT YOUR LOCATION

SIGN THE DOCUMENT AND PRINT YOUR NAME

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WITNESSING  
PROCEDURE

YOUR TWO  
WITNESSES MUST  
SIGN AND DATE  
YOUR DOCUMENT  
BELOW THEY MUST  
ALSO PRINT  
THEIR NAMES AND  
ADDRESSES

WITNESS #1

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 of any parent organization of the health care facility.

SIGNATURE OF FIRST WITNESS

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

WITNESS #2

SIGNATURE OF SECOND WITNESS

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

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**TEXAS DIRECTIVE  
TO PHYSICIANS AND FAMILY OR SURROGATES – PAGE 1 OF 5**

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INSTRUCTIONS

**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. 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 may also wish to complete a directive related to the donation of organs and tissues.

**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:

PRINT YOUR  
NAME

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**TEXAS DIRECTIVE  
TO PHYSICIANS AND FAMILY OR SURROGATES – PAGE 2 OF 5**

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TERMINAL  
CONDITION

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:

INITIAL THE  
STATEMENT  
THAT REFLECTS  
YOUR WISHES

\_\_\_\_\_ 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)

IRREVERSIBLE  
CONDITION

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:

INITIAL THE  
STATEMENT  
THAT REFLECTS  
YOUR WISHES

\_\_\_\_\_ 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)

STATE SPECIFIC  
TREATMENT  
REQUESTS  
(IF ANY)

*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. If you wish, you can also specify that you would like to make an organ donation. Be sure to include any restrictions, such as who may become a donee, what organs you authorize to be donated, etc.)*

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**TEXAS DIRECTIVE  
TO PHYSICIANS AND FAMILY OR SURROGATES – PAGE 3 OF 5**

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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.

DESIGNATION OF A SPOKESPERSON

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:

IF YOU HAVE COMPLETED A MEDICAL POWER OF ATTORNEY DO NOT COMPLETE THIS SECTION

1. \_\_\_\_\_  
(name of person)

2. \_\_\_\_\_  
(name of second person)

(IF A MEDICAL POWER OF ATTORNEY HAS BEEN EXECUTED, THEN AN AGENT HAS BEEN NAMED AND YOU SHOULD NOT LIST ADDITIONAL NAMES IN THIS DOCUMENT.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that the 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.

SIGN THE DOCUMENT AND PRINT YOUR PLACE OF RESIDENCE

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
(your name) (date)

CITY, COUNTY, STATE OF RESIDENCE

\_\_\_\_\_'\_\_\_\_\_'\_\_\_\_\_  
(city) (county) (State)

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**TEXAS DIRECTIVE  
TO PHYSICIANS AND FAMILY OR SURROGATES – PAGE 4 OF 5**

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WITNESSING  
PROCEDURE

TWO WITNESSES  
MUST SIGN YOUR  
DOCUMENT

WITNESS #1

WITNESS #2

DEFINITIONS OF  
IMPORTANT TERMS

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**WITNESSES**

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 the person’s own self; and
3. that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

**TEXAS DIRECTIVE  
TO PHYSICIANS AND FAMILY OR SURROGATES – PAGE 5 OF 5**

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DEFINITIONS OF  
IMPORTANT  
TERMS  
(CONTINUED)

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 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.

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## YOU HAVE FILLED OUT YOUR ADVANCE DIRECTIVE, NOW WHAT?

1. Your Texas Medical Power of Attorney and Texas Directive are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternate agent(s), doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both sections of your Texas documents.
6. Be aware that your Texas documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician. **Caring Connections does not distribute these forms.**