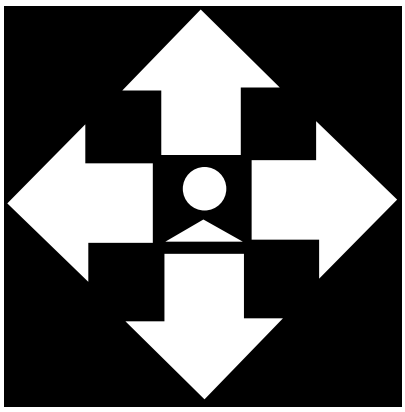

Personal Choices

Communicating Your Healthcare Decisions

If you would like additional information or assistance regarding Advance Directives, please call one of the following:

Patient Relations - 670-2915
Case Management - 670-2412
Pastoral Care - 670-2256

HENDRICK HEALTH SYSTEM

1900 Pine Street • Abilene, Texas 79601

COMMUNICATING YOUR HEALTH CARE CHOICES

Individuals usually make decisions regarding their health care treatment after their physician recommends a course of treatment and provides information about the treatment. These decisions may become more difficult, however, if a patient becomes unable to tell their doctors and loved ones what kind of health care treatment they want. Through documents, known as advance directives, individuals can express their treatment preferences before they actually need such care, ensuring that their wishes will be carried out and that their families and others will not be faced with making these difficult decisions.

This brochure will give you some basic facts about your rights as a patient. Additional information may be obtained from your physician or nurse.

A LITTLE HISTORY

Since the early 1970s, many cases involving the use of life support systems have gone before the courts. The main questions surrounding each case were: 1) whether the life support systems served to prolong life or to prolong suffering prior to inevitable death and 2) whose right was it to decide whether to continue or withdraw particular therapies.

A 1980 Presidential Commission recognized that each of us is unique and that decisions will vary from person to person. They may be based upon a combination of factors, including the lifestyle you lead, your religious or moral views, and upon past experiences. The commission emphasized that it is your right as a patient to be adequately informed of your choices by your physician and to decide what type of medical treatment you wish to receive. Decisions to accept or reject life-sustaining therapies must be made voluntarily by competent and informed patients, or if the patient is unable or incompetent, by another appropriately informed person acting on the patient's behalf.

AT HENDRICK HEALTH SYSTEM

Every Hendrick patient will receive life support, including CPR, unless a decision not to resuscitate (to revive from apparent death) has been made. This is called a "No Code" order and is made only after thoughtful discussion between the physician, the competent patient and/or any others involved in the decision making process. In keeping with applicable federal and state privacy laws, it is the physician's responsibility to inform those involved of the patient's diagnosis and likelihood of recovery.

CONSENT TO MEDICAL TREATMENT

Informed Consent

You have the right to decide what may be done to your body during the course of medical treatment. Your physician will discuss with you the nature of your condition, the proposed treatment and any alternate procedures that are available. Your physician also will provide you with information about the risks associated with certain medical procedures. This information will help you make an informed decision about the kind of treatment you want to receive.

Surrogate Decision-Maker

If you become unable to make your own healthcare decisions and do not have a legal guardian or someone designated under a Medical Power of Attorney, then certain family members and others can make medical treatment decisions on your behalf.

LEGAL ASPECTS OF ADVANCE DIRECTIVES

An advance directive does not need to be notarized. Neither this hospital nor your physician may require you to execute an advance directive as a condition for admittance or receiving treatment in this or any other hospital. The fact that you have executed an advance directive will not affect any insurance policies you may have.

HOSPITAL POLICIES FOR IMPLEMENTING PATIENTS' RIGHTS

Formal policies have been adopted to assure that your rights to make medical treatment decisions will be honored to the extent permitted by law. This hospital has adopted policies relating to informed consent, and implementation and treatment decisions under the Advance Directives Act and the Declaration of Mental Health Treatment.

Complaints concerning advance directive requirements may be filed by calling the Texas Department of State Health Services, 888-963-7111.

IN THIS BOOKLET...

You will find explanations of a Directive to Physicians, Medical Power of Attorney, Out-of-Hospital Do-Not-Resuscitate Order, Mental Health Directive and Uniform Donor Card. If you wish to execute any of those documents, please remove them from the booklet and proceed. Above all, make sure your family knows your wishes! If you have any questions on any of these documents, please call Hendrick Patient Relations Department at 670-2915.

ADVANCE DIRECTIVES

Below is some general information on the five types of advance directives recognized under Texas law. Advance directives can be changed or cancelled at any time.

Directive to Physicians-(Living Will)

A Directive to Physicians, also known as a "living will," allows you to tell your physician not to use artificial methods to prolong the process of dying if you are terminally ill. A Directive does not become effective until you have been diagnosed with a terminal condition.

If you sign a Directive, talk it over with your physician and ask that it be made part of your medical record. If for some reason you become unable to sign a written Directive, you can issue a Directive verbally or by other means of non-written communication in the presence of your physician.

If you have not issued a Directive and become unable to communicate after being diagnosed with a terminal condition, your attending physician and legal guardian or certain family members in the absence of a legal guardian, can make decisions concerning withdrawing or withholding life-sustaining treatment. Your attending physician and another physician not involved in your care also can make decisions to withdraw or withhold life-sustaining treatment if you do not have a guardian and certain family members are not available.

Medical Power of Attorney

Another type of advance directive is a Medical Power of Attorney, which allows you to designate someone you trust - an agent - to make health care decisions on your behalf should you become unable to make these decisions yourself.

You cannot choose as your agent your health care provider, including a physician, hospital or nursing home; an employee of your health care provider, unless he is your relative; your residential care provider, such as a nursing home or hospice; or an employee of your residential care provider, unless he is related to you.

The person you designate has authority to make health care decisions on your behalf only when your attending physician certifies that you lack the capacity to make your own health care decisions. Your agent cannot make a healthcare decision if you object, regardless of whether you have the capacity to make the health care decision yourself, or whether a Medical Power of Attorney is in effect.

Your agent must make health care decisions after consulting with your attending physician, and according to the agent's knowledge of your wishes, including your religious and moral beliefs. If your wishes are unknown, your agent must make a decision based on what he believes is in your best interest.

Out-of Hospital Do-Not-Resuscitate Order

An Out-of-Hospital DNR Order allows you to refuse certain life-sustaining treatments in any setting outside of a hospital (these settings include hospital outpatient and emergency departments, as well as physicians' offices). This advance directive must be used in conjunction with your attending physician.

Declaration for Mental Health Treatment

Another type of advance directive deals with mental health treatment issues only. A Declaration for Mental Health Treatment allows you to tell health care providers your choices for mental health treatment in the event that you become incapacitated.

Organ and Tissue Donation

Each of us is able to make a special gift to someone in need by becoming an organ and tissue donor. Hundreds of organs and tissues are wasted each year that could be used to save lives or return individuals to full, productive lives.

This problem occurs because most families have difficulty making this decision to donate at the time of their loved one's death if they have not talked about it before.

By discussing it now, you can let your family and friends know your feelings. You can help someone fight terminal or debilitating illness with organ and tissue donation. Almost anyone from 0-70 years of age can be organ and tissue donors. Sign up to become an organ and tissue donor at **www.donatelifetexas.org**. For questions related to organ and tissue donations, **please call 1-800-788-8058**.

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 your wishes, including your religious and moral beliefs, when you are no longer capable of making them 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 competence to make 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.

It is important that you discuss this document with your physician 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 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 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 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 this 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 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 health care 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 a health care 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 health care facility or of any parent organization of the health care 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.

MEDICAL POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT

I, _____ *(print your name),* appoint:

Name of Agent:_____ Relationship:_____

Address:_____

_____ Phone:_____

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.

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

_____

_____

_____

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:_____

Address:_____

_____ Phone:_____

B. Second Alternate Agent

Name:_____

Address:_____

_____ Phone:_____

The original of this document is kept at:

_____

_____

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 understand 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 _____ day of

_____(month)_____(year) at

_____

City and State

_____

Signature

_____

Print Name

_____

Date of Birth Social Security Number

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 or of any parent organization of the health care facility.

Signature:_____

Print Name:_____ Date:_____

Address:_____

SIGNATURE OF SECOND WITNESS

Signature:_____

Print Name:_____ Date:_____

Address:_____

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

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 usually are 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 you 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 also may wish to complete a directive related to the donation of organs and tissues.

DIRECTIVE

I, _____ *(print your name)*, 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:

_____ *(initial)* 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

_____ *(initial)* I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

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)* 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

_____ *(initial)* 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 <u>not</u> want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you <u>do</u> or <u>do not</u> 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 a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

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._____
Name *Address* *Phone*

2._____
Name *Address* *Phone*

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.

Signed_____ Date_____

City, County, State of Residence_____

Date of Birth _____ Social Security Number_____

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 himself/herself; 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 your physician, family or other important people 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 people in you life.

NOTES:

NOTICE TO PERSON MAKING A DIRECTIVE FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about mental health treatment and specifically three types of mental health treatment: (1) psychoactive medication, (2) convulsive therapy and (3) emergency mental health treatment. The instructions that you include in this declaration will be followed only if a court believes that you are incapacitated to make treatment decisions. Otherwise, you will be considered able to give or withhold consent for the treatments.

This document will continue in effect for a period of three years unless you become incapacitated to participate in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapacitated.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapacitated. YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED BY A COURT TO BE INCAPACITATED. A revocation is effective when it is communicated to your attending physician or other health care provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration is not valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

DECLARATION FOR MENTAL HEALTH TREATMENT

I, _____ *(print your name)*, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court that my ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, is impaired to such an extent that I lack the capacity to make mental health treatment decisions. "Mental health treatment" means electroconvulsive or other convulsive treatment, treatment of mental illness with psychoactive medication and preferences regarding emergency mental health treatment.

(OPTIONAL PARAGRAPH) I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychoactive medications are as follows:

I consent to the administration of the following medications:

_____

I do not consent to the administration of the following medications:

_____

I consent to the administration of a federal Food and Drug Administration approved medication that was only approved and in existence after my declaration and that is considered in the same class of psychoactive medications as stated below:

Conditions or limitations:_____

_____

_____

CONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding convulsive treatment are as follows:

I consent to the administration of convulsive treatment.

_____

I do not consent to the administration of convulsive treatment.

_____

Conditions or limitations:_____

_____

_____

PREFERENCES FOR EMERGENCY TREATMENT

In an emergency, I prefer the following treatment FIRST *(circle one)* Restraint/Seclusion/Medication.

In an emergency, I prefer the following treatment SECOND *(circle one)* Restraint/Seclusion/Medication.

In an emergency, I prefer the following treatment THIRD *(circle one)* Restraint/Seclusion/Medication.

I prefer a male/female to administer restraint, seclusion, and/or medications.

Options for treatment prior to use of restraint, seclusion, and/or medications:

Conditions or limitations:_____

_____

ADDITIONAL PREFERENCES OR INSTRUCTIONS

Conditions or limitations:_____

_____

Signature of Principal:_____ Date: _____

Date of Birth:_____ Social Security Number: _____

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal's name has been represented to me by the principal, that the principal signed or acknowledged this declaration in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, and that I am not a provider of health or residential care to the principal, an employee of a provider of health or residential care to the principal, an operator of a community health care facility providing care to the principal, or an employee of an operator of a community health care facility providing care to the principal.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to and do not have a claim against any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature:_____

Print Name: _____

Date:_____

Address: _____

Witness Signature:_____

Print Name: _____

Date:_____

Address: _____

INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.
APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.
IMPLEMENTATION: A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:
Section A - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.
Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.
Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.
Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.
Section E - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.
Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is not a representative of the ethics or medical committee of the health care facility in which the person is a patient.
In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.
REVOCATION: An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.
AUTOMATIC REVOCATION: An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS

Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state**.** [HSC §166.002(12)].
Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]
Qualified Relative: A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.
Qualified Witnesses: Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.
Report problems with this form to the Texas Department of State Health Services (DSHS) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC§166.011

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Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic # _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of_____. The above noted person personally appeared before me and signed the above noted declaration on this date:_____.

Signature & seal: _____Notary's printed name:_____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

HENDRICK
HEALTH SYSTEM

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