COMBINED LIVING WILL AND ADVANCE HEALTHCARE DIRECTIVE

State of residence: TX **Place of paper signing:** TX **Effective Date:** [DATE]

I, **[DECLARANT NAME]**, born [DATE], residing at [DECLARANT ADDRESS] (the "Declarant," "Principal," or "Patient"), being of sound mind and at least eighteen (18) years of age, voluntarily make this **Combined Advance Healthcare Directive** — comprising a **Living Will** (statement of treatment wishes) and a **Healthcare Power of Attorney** (appointment of a healthcare agent) — under the laws of the State of TX, as a directive to physicians, my healthcare agent, family members, and all other persons concerned with my care.

1. Statement of Capacity and Voluntariness

I am competent to make this directive. I understand its contents and legal effect. I am not acting under duress, fraud, or undue influence. I make this directive freely and voluntarily, after reflection on the medical, personal, moral, and (where applicable) religious implications of the choices expressed herein.

2. Appointment of Healthcare Agent

I hereby appoint the following person as my Healthcare Agent (the "Agent") to make healthcare decisions for me if I lose the capacity to make them myself:

- **Name:** [PRIMARY AGENT FULL LEGAL NAME]
- **Relationship:** [RELATIONSHIP TO YOU]
- **Address:** [PRIMARY AGENT ADDRESS]
- **Phone:** [PRIMARY AGENT PHONE]

First Alternate Agent (serves if the primary Agent is unavailable, unwilling, or unable):

- **Name:** [ALTERNATE AGENT FULL LEGAL NAME RECOMMENDED]
- **Address:** [ALTERNATE AGENT ADDRESS]
- **Phone:** [ALTERNATE AGENT PHONE]

Second Alternate Agent (serves if both prior Agents are unavailable):

- **Name:** [SECOND ALTERNATE AGENT FULL LEGAL NAME]
- **Phone:** [SECOND ALTERNATE AGENT PHONE]

When authority begins. My Agent's authority begins when a physician determines in writing that I lack the capacity to make or communicate my own healthcare decisions, and ends when I regain capacity.

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Scope of authority. My Agent has full authority to make all healthcare decisions I could make if I had capacity, including (without limitation): consenting to, refusing, or withdrawing any medical treatment, service, or procedure; selecting, hiring, and discharging physicians, nurses, therapists, and facilities; authorizing or refusing artificial nutrition, hydration, and life-sustaining treatment (consistent with any explicit instructions in this directive); obtaining medical information relevant to an authorized decision; making decisions about pain management, palliative sedation, hospice, and comfort care; admitting me to or discharging me from hospitals, nursing homes, assisted-living facilities, and hospice programs; authorizing an autopsy; directing disposition of my remains; and making an anatomical gift of my body or parts thereof consistent with any instruction below.

Agent obligation. My Agent shall make decisions consistent with my wishes as stated in this directive. Where my wishes are unknown or do not clearly address a specific circumstance, my Agent shall act in my best interest after consulting with my attending physician and weighing the burdens and benefits of treatment.

Ineligible persons. My Agent is not my attending physician, an employee of my attending physician, or an owner/operator/employee of a residential healthcare facility where I reside (unless related to me by blood, marriage, or adoption).

Nomination of guardian/conservator. If a court proceeding is ever initiated to appoint a guardian or conservator of my person, I nominate my Agent (and the alternates, in order) to serve in that capacity, to the maximum extent permitted by law.

3. Statement of Treatment Wishes (Living Will)

Treatment choices. A blank or unselected item states no preference on that item. It is not consent, refusal or a medical order. Where a specific instruction applies, it takes priority over a general goal. A choice about ventilation does not choose CPR for me.

Overall philosophy. No specific instruction.

Conditions under which this directive applies. This directive takes effect if I am unable to make or communicate healthcare decisions and my attending physician (or, where required, two physicians) determines that I am in any of the following conditions:

Specific Treatment Instructions

Artificial Nutrition and Hydration (feeding tubes, IV fluids) — initial _____. No specific instruction.

Cardiopulmonary Resuscitation (CPR). No specific instruction.

Mechanical Ventilation. No specific instruction.

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Dialysis. No specific instruction.

Antibiotics. No specific instruction.

Blood Transfusions. No specific instruction.

Emergency care and travel. These are personal instructions, not an emergency medical order. Review emergency orders with an authorized clinician for the setting where I receive care. When I travel or transfer, my care team should check the destination's requirements. Texas recognizes qualifying out-of-state DNR orders; this directive is not such an order. See the Texas out-of-hospital program.

Pregnancy and the place of care

These instructions describe future decisions if I cannot decide for myself. They do not report a diagnosis. The place where care is provided may change which law applies. **Texas — treatment during pregnancy.** If I am pregnant, no one may rely on the Texas directive-to-physicians law to withhold or withdraw treatment that, in reasonable medical judgment, is necessary to sustain my life and without which I will die. That definition excludes medicines for pain relief and procedures for comfort. The restriction in Texas Health and Safety Code §166.049 has no fetal-viability exception. It concerns decisions under Subchapter B, including decisions made for me under that subchapter.

Out-of-hospital resuscitation. If responders know I am pregnant, Texas Health and Safety Code §166.098 bars them from withholding CPR or the other life-sustaining procedures designated under the out-of-hospital DNR program on the basis of that program. These preferences do not create an emergency medical order.

Texas — my health care agent. Pregnancy alone does not end my agent's appointment. Under Texas Health and Safety Code §166.152, my agent may make a health care decision only after my attending physician certifies my incompetence in writing and files the certification in my medical record. Even then, treatment may neither be given nor withheld over my objection. My agent cannot consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, abortion, or neglect through omission of care primarily intended for my comfort.

5. Agent access to decision-related records

When my Agent has legal authority to make a healthcare decision for me, the Agent may obtain information relevant to that authority under 45 C.F.R. § 164.502(g), subject to applicable exceptions. Appointment alone is not blanket permission to disclose my records. Separate consent may be needed for specially protected records.

9. Preferred Setting for Care

I express no specific preference regarding care setting; my Agent and care team may decide based on the circumstances.

10. Personal Message to My Loved Ones and Caregivers

[PERSONAL MESSAGE TO LOVED ONES AND]

11. Revocation

I may revoke this directive at any time and in any manner that communicates my intent to revoke, regardless of my mental or physical condition. Methods of revocation include: (a) a signed and dated written revocation; (b) physical destruction of this directive with intent to revoke; (c) an oral statement of revocation made to my Agent or to a healthcare provider; or (d) the execution of a subsequent directive that, in whole or in part, supersedes this one.

12. Effect of Copy

A copy of this executed directive has the same force and effect as the signed original. I authorize my Agent, physicians, hospitals, and family members to rely on a photocopy, scan, facsimile, or electronic copy of this document.

13. Severability and Governing Law

If any provision of this directive is held invalid or unenforceable, the remaining provisions shall continue in full force and effect. This directive shall be governed by the laws of the State of TX, provided that it shall also be given effect in any other jurisdiction to the extent permitted by that jurisdiction's law.

Patient Self-Determination Act Notice

Under the federal Patient Self-Determination Act of 1990 (42 U.S.C. §§1395cc(f), 1396a(w)), hospitals, nursing homes, home health agencies, hospices, and HMOs participating in Medicare or Medicaid are required to ask adult patients whether they have an advance directive, to provide information about advance directives, and to not discriminate in care based on the existence or non-existence of a directive.

Texas Notice — Statutorily Separate Forms

For a Texas directive to physicians, §166.032 governs execution. The directive must be signed with two qualified witnesses or acknowledged before a notary. Section 166.033 supplies an optional form. Texas requires a medical power of attorney substantially in the form prescribed by §166.164 and executed under §166.154. To make a Texas appointment, use the Texas medical power of attorney form.

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Signature of Declarant

I sign this directive knowingly, voluntarily, and after careful consideration.

Declarant

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Paper signing location. TX. If the place of signing and the place of care differ, check the rules for both. The residence entry does not establish where this document was signed.

Statement of Witnesses

Each of the undersigned witnesses attests under penalty of perjury that:

1. The Declarant is personally known to me (or proved identity by satisfactory evidence) and signed or acknowledged this directive in my presence;
2. The Declarant appears to be of sound mind and under no duress, fraud, or undue influence;
3. I am at least eighteen (18) years of age;
4. I am not the person appointed as Agent by this directive;
5. I am not the Declarant's attending physician, an employee of the attending physician, or an operator or employee of a healthcare facility where the Declarant is a patient or resident (unless related to the Declarant);
6. To the best of my knowledge, I am not entitled to any portion of the Declarant's estate upon death under any existing will or by operation of law.

Witness 1

_____
PRINTED NAME

_____
SIGNATURE

_____
DATE

Witness 2

_____
PRINTED NAME

_____
SIGNATURE

_____
DATE

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Distribution

This directive shall be distributed to, at minimum: (a) my primary-care physician; (b) my healthcare Agent and any alternate Agents; (c) the hospital or healthcare facility where I typically receive care; (d) close family members; and (e) if applicable, my state's advance-directive registry.

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