Instructions for completing this document:

This is an important legal document known as an Advance Directive. An Advance Directive provides an avenue for you to consider whether and to what extent your child, _____, would desire life-sustaining treatment to be provided to him/her considering his/her medical condition, and to document and communicate those desires for life-sustaining treatment to his/her medical providers. These decisions and communications would be beneficial because _____ has been diagnosed with a "terminal" or "irreversible" medical condition.

An "irreversible" condition is a condition (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. A "terminal" condition is 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. Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as that caused by severe intraventricular hemorrhage 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 life-sustaining treatment, the patient is not expected to live. Severe traumatic injury may also cause a person to become irreversibly or terminally ill.

It is in the case of terminal or irreversible illnesses and conditions that you, as the person with legal authority to consent for _____, should consider whether and to what extent your child would want life-sustaining treatment. "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, renal dialysis treatment, and artificial hydration and nutrition. "Artificial nutrition and hydration" includes 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).

The term "life-sustaining treatment" <u>does not include</u> 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. Regardless of whether life-sustaining treatment is chosen, your child's physician will endeavor to manage and minimize his/her pain.

While you are the person with legal authority to direct _____'s medical treatment, the decisions regarding whether and to what extent life-sustaining treatment is desired should be consistent with _____'s desires, if known. In thinking about terminal and irreversible illnesses, you may wish to consider the relative benefits and burdens that life-sustaining treatment would likely provide and determine what treatment, if any, would be acceptable to your child in an effort to achieve a particular outcome. This is a very personal decision that should be made after discussing the matter with your child, if possible, your child's physician, as well as family members or other important people in your child's life. You may wish to reflect on the personal values of your child in making these decisions.

Listed below are choices regarding whether and to what extent life-sustaining treatment is desired. You may initial the treatment choices that best reflect your preferences for treatment. You should provide a copy of the signed directive to _____'s physician and the hospital staff so they can know the treatment decisions that have been made. Consider reviewing this document periodically so that you can best assure that the directive continues to reflect the desired preferences for life-sustaining medical care.

DIRECTIVE

I, [name of parent or guardian] _____ understand that _____ has been certified to have a terminal or irreversible medical condition. I recognize that the best health care is based upon a partnership of trust and communication with my child's physician, and I will make health care decisions together with _____'s physician, consistent with the treatment preferences of my child, if known. I direct that the following treatment preferences for _____ be honored:

____ I request that all treatments other than those needed to keep _____ comfortable be discontinued or withheld and that _____'s physician allow him/her to die as gently as possible; OR

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

Additional requests: (After discussion with your child's physician, you may wish to consider listing particular treatments in this space that you do or do not want to be given to your child in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want a particular treatment.)

_____

_____

_____

If, after signing this directive, I elect hospice care for _____, I understand and agree that only those treatments needed to keep _____ comfortable will be provided and he/she will not be given available life-sustaining treatments.

This directive will remain in effect until I revoke it. No other person may do so.

Signed_____ Date_____

City, County, State of Residence _____

Relationship to Patient _____

Address and Phone Number _____
_____
_____

Two competent adult witnesses must sign below, acknowledging the signature of the parent or guardian 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_____Witness2_____
(Printed Name) _____ (Printed Name)_____

IF THE PATIENT PREFERS TO HAVE THE DIRECTIVE TO PHYSICIANS FOR MINOR CHILD OR WARD SIGNED BEFORE A NOTARY PUBLIC INSTEAD OF USING TWO WITNESSES, THIS PAGE CAN BE SUBSTITUTED FOR PAGE 4.

This directive will remain in effect until I revoke it. No other person may do so.

Signed_____ Date_____

City, County, State of Residence _____

Relationship to Patient _____

Address and Phone Number _____
_____
_____

STATE OF TEXAS §
§
COUNTY OF BEXAR §

This DIRECTIVE TO PHYSICIANS FOR MINOR CHILD OR WARD was acknowledged before me on the ____ day of _____, 20____, by _____.

_____
NOTARY PUBLIC
FOR THE STATE OF TEXAS
My Commission Expires: _____