Uniform Donor Card

Signed by the donor and the following two witnesses in the presence of each other

Signature of Donor _____ Date of Birth of Donor _____

Date Signed _____ City & State _____

Witness _____ Witness _____

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

For further information consult you physician or call:

Texas Organ Sharing Alliance 1-800-275-1744

Val Verde Regional Medical Center

Quality health care here at home.

Critical Choices Handbook

Includes Advance Directives

Uniform Donor Card

Of _____
Print or type name of donor

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give: (a)_____ any needed organs or tissues

(b)_____ only the following organs or tissues

_____
Specify the organ(s) or part(s)

for the purpose of transplantation, therapy, medical research or education.

(c)_____ my body for anatomical study if needed.

Limitations or special wishes, if any: _____

There may come a time when you or a member of your family becomes seriously injured or critically ill. In the midst of your shock and grief you may be asked to make difficult decisions about the intensity of medical care to be administered or about whether to withdraw "life sustaining" treatment and change the goal of treatment from cure to comfort.

Because it is harder to make these decisions when you are under stress, it is important for you to know about the types of treatment and life sustaining procedures available. You can decide what kind of treatment you want before you and your family are called upon to make these decisions. Such decisions are usually made with the following things in mind:

- The patient's wishes, especially in a "Directive to Physicians and Family and Surrogate" or "Medical Power of Attorney".
- The patient's medical history and current condition.
- The benefits of treatment to the patient.
- The amount of harm or amount of suffering for the patient involved in treatment.
- The probability of success or futility of treatment.
- The possibility of eventual discharge from the hospital in a condition that reflects the quality of life that is important to the patient/family.

Cardiopulmonary Resuscitation (CPR)

This involves the emergency use of medications and electrical and mechanical treatments in an effort to restore heartbeat, blood pressure and breathing if the heart and/or lungs stop working.

Life Sustaining Treatments

Generally, these involve life sustaining medications, treatments and machines designed to sustain the life of a patient and without which the patient will die. These treatments include but are not limited to

- Artificial ventilation – mechanical breathing machine also known as a ventilator.
- Cardiac assist devices – balloon pump or other devices which temporarily support the pumping functions of the heart.
- Artificial nutrition and hydration – nutrients or fluids given through a tube inserted into a vein, under the skin or into the stomach.
- Kidney Dialysis – use of an artificial kidney machine.

How Do We Decide?

Most medical treatment given in the hospital is aimed at a cure–making the patient better or well enough to be discharged to another facility or home. But for some patients, particularly those with an incurable or irreversible illness, it may be appropriate to change the goal of treatment from cure to comfort and to change from using life prolonging procedures to those which will prevent suffering and preserve dignity.

Two Questions Often Asked in This Situation Are:

"What would the patient tell you to do if the patient could talk to you right now?" and "What is the most loving thing to do?"

Remember You Need Not Be Alone in Your Decision Making

Hospital staff is available to help you come to the best decision for you and your loved one(s). In addition to our fine nurses, we have a chaplin and patient advocate on staff available to listen, clarify information and support you in your decision.

As a patient, medical treatment decisions are made in a partnership of trust between the physician and patient. Occasionally, very difficult decisions must be made by the patient or the patient's loved ones, creating anxiety and doubts about what is the right thing to do. The hospital offers the services of the Medical Ethics Committee to assist patients and families with any concerns related to treatment decisions. The committee is made up of doctors, nurses, a chaplain and social workers with experience helping patients and families through difficult discussions and decisions. The committee's services are free and confidential. To reach the Medical Ethics Committee, ask your caregiver or call the hospital operator and request a consult with the Medical Ethics Committee.

How Do We Make Our Wishes Known?

Texas law allows you to make an Advance Directive concerning your medical care. That is, you make your wishes concerning medical treatment known before you actually need such care. There are several types of Advance Directives: The "Directive to Physicians and Family or Surrogate", the "Medical Power of Attorney", and the "Out-of-Hospital Do-Not-Resuscitate Order". Forms for most of these are provided for your convenience at the end of this booklet. "Out-of-Hospital Do-Not-Resuscitate Order" form may be obtained through your health care facility. **You do not have to issue an Advance Directive.** In fact, a physician, health facility, health care provider, insurer or health care service plan cannot require that you issue an Advance Directive as a condition for obtaining insurance for health care services or for receiving health care services.

Advance Directives

Directive to Physicians and Family or Surrogate

The "Directive to Physicians and Family or Surrogate" establishes a mechanism that allows you to provide, in advance, for the withdrawal or withholding of medical care should you be certified by your physician as suffering from terminal or irreversible condition.

You may issue a "Directive to Physicians and Family or Surrogate" by written or verbal means if you are a competent adult. The Directive must be issued in the presence of two qualified witnesses. Those people who cannot serve as witnesses are defined on the "Directive to Physician and Family or Surrogate" form in this booklet. Your Directive does not need to be notarized.

Your Directive does not become operative until you have been diagnosed and certified in writing by your physician to be afflicted with a terminal or irreversible condition. You may revoke your Directive at any time, even in the final stages of a terminal or irreversible condition. An expressed desire to receive life-sustaining treatment will supersede the effect of a Directive.

If you have not issued a Directive, your legal guardian, an agent under a Medical Power of Attorney, or certain family members, in conjunction with the attending physician, may make decisions concerning the withholding or withdrawal of life-sustaining treatment when you have been certified as having a terminal or irreversible condition and are comatose, incompetent, or otherwise mentally or physically incapable of communicating your wishes.

Medical Power of Attorney

The Medical Power of Attorney for Health Care allows you to designate a third party as your agent for purposes of making any health care decision should you become incapable of making such decisions for yourself. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, abortion or the neglect of you refusing to allow care primarily intended for your comfort.

You must sign a Medical Power of Attorney in the presence of two qualified witnesses. Before executing the Medical Power of Attorney, you must sign a statement that you have received a disclosure statement, and read and understood its contents. **Your Medical Power of Attorney does not need to be notarized.**

Your agent may exercise authority to make health care decisions only if your attending physician certifies in writing in the medical record that based upon the physician's medical judgement, you lack the competence to make health care decisions for yourself.

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.

Acknowledgement 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)

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 or of any parent organization of the health care facility.

Signature:_____

Print Name:_____Date:_____

Address:_____

Signature of Second Witness

Signature:_____

Designation of Health Care Agent

I, _____(insert your name) appoint:

Name:_____

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 automatically is 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:_____

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 your family or chosen spokesperson, as well as your physician. Your physician, other health care provider or medical institutions 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 relative to the donation of organs and tissues.

DIRECTIVE

I, _____(insert 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 the available life-sustaining treatment provided in accordance with prevailing standards of medical care:

____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld, and my physician allow me to die as gently as possible; OR
____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld, and my physician allow me to die as gently as possible; OR
____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

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

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:

1. _____

2. _____

(If a Medical Power of Attorney has been executed, then an agent already 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 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_____

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 care 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 nutrition and hydration. 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 judgment will produce death within six months, even with the 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.

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 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 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 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, or business office employee of the health care