CONSENT TO MEDICAL TREATMENT
(Procedure for Patient without Advanced Directives)

Attached is a printout describing the procedure to follow in the absence of an executed advance directive. Decisions made under these procedures may include the withholding or withdrawing of life sustaining treatment. Any treatment decision made under these procedures must be based on knowledge of what the patient would desire, if known, and must be documented in the patient's medical record and signed by the attending physician.

Procedure When Person has Not Executed or Issued a Directive and is Incompetent or Incapable of Communication

(Surrogate Decision that may include withholding or withdrawing life sustaining treatment)

"Qualified patient" means a patient with a terminal or irreversible condition that has been diagnosed and certified in writing by the attending physician.

"Irreversible condition" means a condition, injury or illness:

a. that may be treated but is never cured or eliminated;
b. that leaves a person unable to care for or make decisions for the person's own self; and
c. that without life-sustaining treatment provided in accordance with the prevailing standard of medical care is fatal.

"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.

The Advance Directives Act (see Chapter 166.039, Health and Safety Code)

If an adult qualified patient has not executed or issued a directive and is incompetent, or otherwise mentally or physically incapable of communication, the attending physician and the resident's legal guardian or an agent under a medical power of attorney may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the resident.

If the patient does not have a legal guardian or an agent under a medical power of attorney, the attending physician and **one person**, if available, from one of the following categories, in the following priority, may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment.

- the patient's spouse;
- the patient's reasonably available adult children;
- the patient's parents; or
- the patient's nearest relative

A treatment decision must be based on knowledge of what the patient would desire, if known, and must be documented in the patient's medical record and signed by the attending physician.

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If the patient does not have a legal guardian and a person listed in this section is not available, a treatment decision made under this section must be concurred in by another physician who is not involved in the treatment of the patient or who is a representative of an ethics or medical committee of the health care facility in which the person is a patient.

The fact that an adult qualified patient has not executed or issued a directive does not create a presumption that the patient does not want a treatment decision to be made to withhold or withdraw life-sustaining treatment.

A relative listed in this section who wishes to challenge a treatment decision made by other relatives under this section must apply for temporary guardianship under Section 875, Texas Probate Code. The court may waive applicable fees in that proceeding.

_____, has not executed or issued a directive and has no legal guardian or an agent under a medical power of attorney. The above named individual is incompetent, or otherwise mentally or physically incapable of communication. The following is a brief description of:

1. the patient's physical and mental condition, including diagnoses and description of terminal illness:

_____

_____

2. any treatment desires of the patient known:

_____

_____

3. physician or physician/family-determined treatment decisions:

_____

_____

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Attending Physician:

_____ Date: _____

Family Member Signature:

_____ Date: _____

Relationship to Patient: _____

Second Physician (if required):

_____ Date: _____

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DECLARATION FOR MENTAL HEALTH TREATMENT

I,_____, 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:

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☐ 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: _____

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SIGNATURE ACKNOWLEDGED BEFORE NOTARY PUBLIC

State of Texas

County of_____

This instrument was acknowledged before me on _____(date) by _____(name of notary public).

_____
NOTARY PUBLIC, State of Texas

Printed name of Notary Public:
_____

My commission expires:_____

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: _____

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NOTICE TO PERSON MAKING A DECLARATION 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: psychoactive medication, convulsive therapy, and 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 either acknowledged before a notary public or signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature