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How to Complete Your Texas Directive to Physicians

Directive to Physicians and Family or Surrogates (Texas Health and Safety Code Section 166.033)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This is Texas's statutory advance directive, often called a **living will**. It tells your doctors whether you want life-sustaining treatment if you have a terminal or irreversible condition and cannot speak for yourself.

1. **Read the instructions and definitions**
   The statutory instructions are on Page 1 and the definitions on the last page. Discuss your wishes with your doctor and family.
2. **Initial your treatment choices (Page 2)**
   For a terminal condition and for an irreversible condition, initial **one** choice each. Initials must be handwritten in ink.
3. **Additional requests and spokespersons (Page 3)**
   List any specific treatments you do or do not want. If you have **no** Medical Power of Attorney, you may name up to two people to decide with your doctor.
4. **Sign one of two ways (Page 3–4)**
   Sign in front of a **notary**, or in front of **two qualified adult witnesses**. Witness 1 cannot be a relative, your spokesperson, your doctor, or an heir. We can also provide witnesses for an additional fee.

After It's Signed

- Give copies to your doctor, your usual hospital, and your family or spokesperson. Texas requires you (or someone for you) to tell your attending physician that you have a directive.
- Emergency medical services follow only an Out-of-Hospital DNR order, not this directive. Ask your doctor if you need one.
- You can revoke it at any time. We have a free Revocation of Advance Directive form.
- Consider also completing a Medical Power of Attorney. We have a free Texas form.

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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Main headquarters: 2315 Capitol Avenue, Sacramento, CA 95816.

This form is provided as a free convenience. First Choice Mobile Notary & Apostille is not a law firm, and a notary public who is not an attorney cannot give legal advice or help you decide what to write on this form. These instructions are general information only and are not legal advice. If you have questions about your situation, consult a licensed Texas attorney. © 2026 First Choice Mobile Notary & Apostille. All rights reserved. This form may be filled in and printed for personal use; it may not be copied, altered, or redistributed for commercial purposes.

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

(Texas Health and Safety Code Section 166.033)

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

DIRECTIVE

I,

Your full 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 or treatment 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:

☐ 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.)

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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 artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not 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 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 health care or treatment decisions with my physician compatible with my personal values:

1. Name (and phone)

2. Name (and phone)

(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.

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X _____

Signed | Date | Printed name

City, County, State of Residence

Sign this directive in ONE of two ways: (1) before a notary public, using the acknowledgment below, **or** (2) in the presence of two competent adult witnesses, using the witness section on the next page (Texas Health and Safety Code Section 166.032).

OPTION 1: NOTARY ACKNOWLEDGMENT

STATE OF TEXAS §

COUNTY OF _____ §

This instrument was acknowledged before me on

Date | by (name of declarant)

X _____

Notary Public, State of Texas

(Notary seal)

Notary's printed name

Notary ID number | My commission expires

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OPTION 2: WITNESSES

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 health care or 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

X _____ | _____ | _____

Signature of witness | Printed name | Date

Witness 2

X _____ | _____ | _____

Signature of witness | Printed name | Date

Definitions:

“Artificially administered 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 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 the person’s own self; 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 persons 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 artificially administered 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 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 persons in your life.

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