# Hospice Informed Consent/Election of Hospice Benefit

Hospice Agency: Amerihealth Group Inc DBA Ameri Hospice

Hospice 24-Hour Number: (972)499-4757

## Informed Consent for Hospice Service/Release of Records

***(Part One of Two Requires Signatures)***

I, _____, have been informed that the above named Hospice Agency, referred to in this consent as the Hospice, offers hospice care under the Medicare/ Medicaid Hospice Benefit Program. I understand the following explanation of the Medicare/Medicaid Hospice Benefit.

*Admission Information:* The Hospice will admit you only if the Hospice is able to provide care appropriate to your needs. If the Hospice is unable to meet your needs, the Hospice will assist you and your representative in locating resources of your choice that can provide the needed services.

*After Hours Access/Inpatient Care*: A nurse is scheduled to respond after hours to patient calls, while the Hospice's office is closed. If a nurse is needed after hours, call the Hospice's phone number provided above. The call will either be answered by a nurse or routed to a nurse via an answering service.

If inpatient palliative support is needed, the Hospice will provide and coordinate inpatient care at a contracted facility. I understand that if I call 911, go to the hospital, or choose care for any conditions related to my admitting hospice diagnosis without preauthorization from the Hospice, I may be responsible for those associated costs.

*Clinical Records*: It is the policy of the Hospice to protect all clinical records against loss, defacement, tampering, and use by unauthorized persons. I authorize the Hospice to release medical information to my physician, the facility of my choice, payer source, or accrediting/regulatory/consulting organizations, as appropriate.

If I transfer to another healthcare entity or facility, the Plan of Care, discharge summary, and medical record, if requested, may be released to the new service providers.

## Financial Authorization

I authorize benefits to be made on my behalf.

❑ Bill Medicare 100% – Medicare Beneficiary Identifier (MBI): _____ Effective Date: _____

❑ Bill Medicaid 100% – Medicaid Beneficiary Number: _____ Effective Date: _____

❑ Bill Primary Insurance: _____% Insurance Co: _____

Beneficiary/Pre-Auth Numbers: _____ Effective Date: _____

❑ Bill Secondary Insurance: _____% Insurance Co: _____

Beneficiary/Pre-Auth Numbers: _____ Effective Date: _____

Benefits are: _____

❑ I will pay any service or supply charge not reimbursed by my insurance company on a monthly basis. I will pay all charges incurred on a monthly basis if I do not have insurance coverage.

# Hospice Informed Consent/Election of Hospice Benefit

## Services/Rights/Hotline/Policies/Procedures

I understand that a Registered Nurse (RN) will case manage all services, and I have accepted the following services:

❑ RN and/or LVN/LPN ❑ Hospice aide ❑ Social worker ❑ Chaplain ❑ Dietitian ❑ Volunteer ❑ PT ❑ OT ❑ ST

❑ Other: _____

I have been notified of my right to voice a complaint and may direct that to the Hospice Administrator, or designee, at the above referenced phone number. The investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt. I may also contact Texas Health and Human Services Commission (HHSC), Complaint and Incident Intake online through the Texas Unified Licensure Information Portal (TULIP) at https://txhhs.force.com/complaint/s/; or by calling 1-800-458-9858 (Monday through Friday, 7am to 7pm). My complaint may also be mailed to Texas Health and Human Services Commission (HHSC), Complaint and Incident Intake, Mail Code E249, P.O. Box 149030, Austin, Texas 78714-9030 or faxed to: 1-877-438-5827 (toll-free) or to 1-512-438-2724. This includes a complaint regarding advance directives.

I can also file a complaint at Medicare.gov or call the Medicare Beneficiary Ombudsman's office at 1-800-MEDICARE (1-800-633-4227, or either 1-877-486-2048 or 711 for TTY users). Representatives are available 24 hours a day, seven days a week. If I still need help after talking with a representative, I can ask to have my inquiry referred to the Ombudsman. For any complaints regarding discrimination, I understand that I may contact the Office for Civil Rights within 180 days of when the situation occurred. The complaint must be filed in writing by mail, fax, email, or online via the OCR Complaint Portal.

Complaints regarding any health insurance services can be mailed to MC 1111A, Consumer Protection, Texas Department of Insurance, PO Box 149091, Austin, Texas 78714, or by calling the Consumer Help Line at 1-800-252-3439, online at http://www.tdi.texas.gov/consumer/complfrm.html, or by email to ConsumerProtection@tdi.texas.gov.

I acknowledge I have received a copy along with a verbal explanation of the following:

- Patient Rights and Responsibilities and Patient Choice Statement
- Rights of the Elderly
- Advance Directives information
- HIPAA/Notice of Privacy Practices information
- Abuse, Neglect, and Exploitation policy
- Emergency Preparedness/Natural Disaster information
- Home Safety information
- Disposal of Controlled Substances and Medication Disposal policies
- Medicare Part D information
- Home Hazardous Waste Disposal information
- Infection Control education
- Hospice Drug Testing policy
- Expected Death (at Home) policy

I have received education on completing an emergency preparedness plan for myself and my family. I understand the importance of completing this plan and know that the Hospice staff may assist in this process.

# Hospice Informed Consent/Election of Hospice Benefit

I understand that the Hospice will review all of my medications to determine if they are related to my hospice diagnosis and related conditions to determine whether medications will be covered by hospice or my Part D plan.

I consent to the Hospice's use and/or disclosure of protected health information for payment, treatment, and the Hospice's healthcare operations.

I have been informed of the availability of clergy and spiritual counseling services.

I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any procedures. I also understand that I must have a primary caregiver.

I have ❑ or have not ❑ signed an advance directive. I am ❑ am not ❑ providing a copy for my record.

Health Care Proxy/Agent/Surrogate/Attorney in Fact: _____ Phone: _____

## Notice of Service Not Covered by Hospice

The following services will not be covered by the Hospice:

- Conditions, medications, and services that are not related to the terminal diagnosis and related conditions.
- A hospitalization in a facility that does not contract with the Hospice.
- Hospitalization without contacting and arranging with the Hospice's nurse.
- Ambulance use without the Hospice's approval.
- Physician appointment without notifying the Hospice's nurse.
- Curative or life extending therapies such as blood or blood products, chemotherapy, radiation, or insertion of PEG feeding tube.
- Anything not related to the Hospice diagnosis and related conditions.
- Sitter services.

The above services are not covered by hospice. The Hospice is reimbursed through Medicare, Medicaid, private insurance, or private pay. This is done on a per diem or per visit basis or schedule.

Due to this, the Hospice must be financially responsible for care provided regarding the terminal diagnosis and related diagnoses and related needs of the Hospice patient. The Hospice Medical Director will determine which conditions are related to the Hospice life-limiting terminal diagnosis.

Medicare guidelines instruct hospices to be professional managers of the patient's care. To do this, the Hospice must be aware of the situations as they arise and be allowed to manage the care of the patient. If the patient/representative desire any of the above non-covered items, the patient/representative will be given a choice of either reinstating the patient's traditional Medicare services and discontinuing hospice services or allowing the patient/representative to pay for the non-covered services.

I must seek pre-approval from the Hospice for all treatments and services not included in the Plan of Care. I will be responsible for all charges incurred for treatments/services with a physician or facility not contracted with the Hospice. I have received a list of all inpatient and respite facilities with which the Hospice has a contract.

# Hospice Informed Consent/Election of Hospice Benefit

## Required Signatures for the Hospice Informed Consent

***(Part One of Two Signatures)***

_____ _____

Beneficiary/Patient Signature Date

X_____ _____

Authorized Beneficiary Representative Signature (if beneficiary is unable to sign) Date

X_____ _____

Relationship to Patient Reason patient is unable to sign

_____ _____

Hospice Agency Representative Signature Date

## Election of the Medicare/Medicaid Hospice Benefit

***(Part Two of Two Requires Signatures)***

I, _____, choose to elect the Medicare Hospice Benefit and receive hospice services from the above named Hospice Agency (the Hospice) to begin on _____ (start of care date).

(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)

## Hospice Philosophy and Effects of Electing the Medicare Hospice Benefit

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice is a holistic, comprehensive type of care for those facing a life-limiting terminal illness. Hospice care concentrates on managing pain and other symptoms related to my terminal illness and related conditions. I acknowledge and understand that hospice care is palliative rather than curative, and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to me and my family/caregivers/representatives. I also acknowledge that I have been given a full understanding of the potential availability of supportive palliative care options outside a hospice setting.

I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.

I have received information on which items, services, and drugs the Hospice will cover and furnish upon my election to receive hospice care, and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.

I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual, and in general the Hospice will be providing virtually all of my care needed while I am under a hospice election.

I understand that items, services, and drugs determined to be unrelated to my terminal illness and related conditions continue to be eligible for coverage by Medicare under separate benefits.

I acknowledge that I have been provided information that the cost sharing for hospice services is minimal and that prescription drugs and inpatient respite care are the only services potentially subject to cost sharing. Hospices may charge coinsurance of five percent

for each prescription provided outside the inpatient setting (not to exceed $5.00) and for inpatient respite care (not to exceed the inpatient hospital deductible).

## Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

As a Medicare beneficiary electing to receive hospice care, I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists conditions, items, services, and drugs that the Hospice has determined to be unrelated to my terminal illness and related conditions, and that will not be covered by the Hospice.

If I request the notification within five days of the Hospice election date, the Hospice will provide the information within five days of my request. If I request the notification at any point after the first five days of the Hospice election date, the Hospice will provide this form within three days of my request.

## Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

I acknowledge that as a Medicare beneficiary, I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the Hospice's determinations, and that I have been provided with the contact information for the BFCC-QIO that services my area, which is Acentra Health: www.acentraqio.com, phone number 888-315-0636, TTY number 711.

I understand that I may revoke my election of the Hospice benefit at any time during a certification period, and thereby resume the Medicare or Medicaid coverage of the benefits I waived. To revoke the election, I understand I must file a written revocation statement with this Hospice Agency. At a later date, I may elect to receive hospice coverage again for the next certification period if I am eligible.

## Waiver of Other Benefits

For the duration of an election of hospice care, I waive all rights to Medicare payments for the following services:

- Hospice care provided by a hospice other than the Hospice designated by me (unless provided under arrangements made by the designated Hospice).
- Any Medicare services that are related to the treatment of my terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services:
    - Provided by the designated Hospice.
    - Provided by another hospice under arrangements made by the designated Hospice.
    - Provided by the individual's attending physician if that physician is not an employee of the designated Hospice or receiving compensation from the Hospice for those services.

## Right to Choose Attending Physician

I understand that I have a right to choose my attending physician to oversee my care if available and agrees to serve in this role. My attending physician will work in collaboration with the Hospice to provide care related to my terminal illness and related conditions.

❑ I do not wish to choose an attending physician.

I acknowledge this choice is of my own free will without coercion. My choice for an attending physician is:

(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full Name: _____ NPI (if known) _____

Office Address: _____

# Hospice Informed Consent/Election of Hospice Benefit

If my chosen attending physician declines to serve in that role, I understand that the Hospice's physicians will manage my medical care related to my terminal illness and related conditions unless I choose a different attending physician.

## Required Signatures for the Election of the Hospice Benefit

***(Part Two of Two Signatures)***

❑ N/A Patient is non-Medicare

❑ N/A I was transferred from _____ on _____.

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by (the Hospice)

_____ with the effective date of election to begin on _____.

I am electing the (1st, 2nd, 3rd, 4th, etc.) _____ benefit period.

Note: The start of care date, also known as the effective date, of the election, which may be the first day of hospice care or a later date but may be no earlier than the date of the election statement as indicated above. An individual may not designate an effective date that is retroactive.

_____ _____

Beneficiary/Patient Signature Date

X_____ _____

Authorized Beneficiary Representative Signature (if beneficiary is unable to sign) Date

X_____ _____

Relationship to Patient Reason patient is unable to sign

_____ _____

Hospice Agency Representative Signature Date

# Patient Notification of Hospice Non-Covered Items, Services, and Drugs

**Hospice Name: _____**

**Hospice Phone: _____**

**Patient Name: _____ MRN: _____**

**Date Furnished: _____ Patient Primary Terminal Diagnosis: _____**

## Purpose of Issuing this Notification

The purpose of this addendum is to notify the requesting Medicare beneficiary (or representative), in writing, of those conditions, items, services, and drugs not covered by the Hospice because the Hospice has determined they are unrelated to your terminal illness and related conditions. If you request this notification within 5 days of the Hospice election date, the Hospice must provide this form within 5 days of your request. If you request this form at any point after the first 5 days of the Hospice election date, the Hospice must provide this form within 3 days of your request.

## Diagnoses Related to Terminal Illness and Related Conditions

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

## Diagnoses Unrelated to Terminal Illness and Related Conditions

1)_____

2)_____

3)_____

4)_____

6)_____

7)_____

8)_____

# Patient Notification of Hospice Non-Covered Items, Services, and Drugs

**Items, Services and Drugs Determined by Hospice to be Unrelated to Your Terminal Illness and Related Conditions (these items, services, and drugs will not be covered under the hospice benefit):**

| Items/Services/Drugs | Reason for Non-coverage |
|---|---|
| 1)_____ | |
| 2)_____ | |
| 3)_____ | |
| 4)_____ | |
| 5)_____ | |
| 6)_____ | |
| 7)_____ | |
| 8)_____ | |

**Note:** The Hospice makes the decision as to whether or not conditions, items, services, and drugs are related for each patient. As the patient or representative, you should share this clinical explanation with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions. The Hospice should provide its reasons for non-coverage under the hospice benefit in language that you (or your representative) can understand.

I acknowledge that as a Medicare beneficiary, I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the Hospice's determinations, and that I have been provided with the contact information for the BFCC-QIO that services my area.

Please check the appropriate state specific BFCC-QIO below, that serves the state that the patient resides in.

Website: ❑ Acentra Health: www.acentraqio.com ❑ Livanta: www.livantaqio.cms.gov/en

BFCC-QIO Name: _____

BFCC-QIO Phone Number: _____

# Patient Notification of Hospice Non-Covered Items, Services, and Drugs

**Note: The 'date furnished' is defined as when the beneficiary (or representative) receives an addendum within 3 to 5 days from their request and not the date of the signature.**

**Signing this notification (or its updates) is only acknowledgment of receipt of the notification (or its updates) and does not necessarily indicate agreement with the Hospice's determinations.**

X _____ _____

Signature of Beneficiary/Patient's Authorized Representative Date Signed

X _____ _____

Representative's Relationship/Reason Patient Unable to Sign Date Signed

❑ Beneficiary and/or Representative refuses to sign

**If the beneficiary and/or representative refuses to sign, the Hospice must document on the addendum below the reason(s) the addendum is not signed. The addendum becomes part of the beneficiary's medical record.**

**Reason(s):** _____

_____

_____

_____ _____

Signature of Witness/Hospice Agency's Representative Date

# Patient Declination / Request for Notification of Hospice Non-Covered Items, Services, and Drugs

I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists conditions, items, services, and drugs that the Hospice has determined to be unrelated to my terminal illness and related conditions, and that will not be covered by the Hospice.

If I request the addendum within five days of the Hospice election date, the Hospice must provide the form within five days of the request. If I request the addendum at any point after the first five days of the Hospice election date, the Hospice must provide the notification within three days of my request. Additionally, if there are changes to the Hospice Plan of Care after the original request that indicate a new illness or condition has arisen, the Hospice will issue an updated addendum to me (or my representative) reflecting whether or not items, services, and supplies related to the new illness or condition will be provided by the Hospice.

I am requesting, in writing, that the Hospice furnish a copy of the above-described addendum. My written request is set forth on this date: _____. The following box checked indicates the point in time I submitted the written request to the Hospice, and how long the Hospice has in turn to furnish the requested addendum.

❑ I submit my request in writing within five days of the Hospice election date then I expect my request to be fulfilled within five days of the written date above.

Or

❑ I submit my request in writing at any point after the first five days of the Hospice election date then I expect my request to be fulfilled within three days of the written date above.

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❑ I am not requesting the addendum. I have been made aware that I can request it at any time.

X _____ _____

Signature of Beneficiary/Patient's Authorized Representative Date

X _____ _____

Representative's Relationship/Reason Patient Unable to Sign Date

_____ _____

Signature of Witness/Hospice Representative Date

**The Hospice furnished the addendum on:** _____

**Date**

# Patient Choice Statement

(To be completed for all new patients/guardians)

I, _____ (patient/guardian name), the undersigned patient/guardian, understand that it is my right to select a hospice provider of my choice.

I have selected _____ (hereafter, the Hospice) free of any undue pressure or solicitation by any officer, director, employee, agent, or contractor of the Hospice. I have been advised by the Hospice that I may request information concerning its scope of practice, services available and telephone numbers. I was encouraged to ask specific questions concerning my individual needs to assess whether the Hospice is a good fit for me. I have been able to ask questions and express concerns, which have been satisfactorily responded to by the Hospice's staff. I further declare that my receipt of hospice services from the Hospice is by choice. I have been advised by the admitting professional that if for any reason I wish to change services to another hospice agency, it is my right to do so.

I am making this request of my own free will and have not been coerced, solicited, or pressured to do so by any employee of the Hospice.

X _____

Signature of Patient/Guardian Date

_____

Signature of Hospice Representative Date

# Primary Care Person Responsibilities

I understand that I am accepting the role as the primary care person for _____.
I further understand this will involve receiving support from this Hospice. The commitment and responsibility of the Hospice is described below. I have a commitment to keep my loved one at home during his/her terminal illness.

I also have a commitment to provide for his or her care as much and as long as I am able to do so.
I understand the Hospice's goal is not to cure a patient's terminal illness, but to reduce symptoms such as pain and nausea and to provide psycho-social and spiritual support to both the patient and the family.

I. I understand the Hospice's obligations are as follows:

A. The Hospice staff will provide instructions to me as needed.
B. The Hospice staff will provide emotional and spiritual support to help me cope with this illness and eventual death. This support will be provided by hospice staff and may include volunteers. Hospice staff will also provide support to me after death through a bereavement program.
C. The Hospice staff will provide patient care by scheduled appointments. Visits will be made to the home and/or nursing facility.

II. I understand the Hospice is available 24 hours a day, and I may call after hours for emergencies.

III. I understand that because the patient and family are cared for as one, the Hospice medical record will contain information about me as well as the patient. Every effort will be made to keep this information confidential. Information about me will be exchanged with the patient.

× _____ _____

Caregiver Signature Date

_____ _____

Hospice Signature Date

# AMERI HOSPICE

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**Patient's Name:** _____
**Last** **First** **Middle**

**Address:** _____

_____

**Home/Cell Telephone #:** _____ **Date of Birth:** _____

**RECIPIENT:** Name of Organization/Individual to whom the Hospital/Facility may disclose my health information including recipient's address, telephone and/or fax #, as applicable.

**Recipient Name:** **AMERI HOSPICE**

**Recipient Address:** **5068 W.Plano,Parkway,Ste 295, Plano,Tx 75093**

**Recipient Fax #:** **(469)965-9727** **Recipient Telephone #:** **(972)499-4757**

**Type of information to be disclosed:** (Check the appropriate boxes and include other information where indicated)

☐ Medical Abstract ☑ Demographics ☑ History & Physical ☑ Discharge Summary ☑ Complete Record ☐ Emergency Room Record
☐ Consultation(s) ☐ Operative Report(s) ☐ Lab Report(s) ☐ Radiology Report(s) ☐ Pathology Report(s) ☐ Other: _____
☐ If applicable: pictures, images, videos. Must specify procedure and date: _____

**Purpose of Disclosure:**

☑ Medical Care ☐ Insurance ☐ Personal ☐ Legal Matters ☐ Disability ☐ Other: _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including A**LCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, AIDS** and **HIV, SEXUALLY TRANSMITTED, TUBERCULOSIS** and other **INFECTIOUS DISEASE** information, as applicable.

***This authorization will automatically expire in 12 months from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition:*** _____

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated. I understand that this disclosure of my health information, in accordance with the terms and conditions of this Authorization, also carries with it the potential for an unauthorized re-disclosure of my health information at which time my information may no longer be protected by federal and state confidentiality laws governing the use and disclosure of my health information.

In accordance with applicable law, disclosure of certain types of sensitive information of minors between the ages of 13 and 17 will not be disclosed without the minor's authorization.

I understand that I may at any time make a written request to the Health Information Department to inspect and/or obtain a copy of my health information as provided in CFR 164.524.

I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of treatment of me, enrollment in the health plan, or eligibility for benefits.

I understand that this Authorization will remain in effect until it expires as set forth above, or I provide a written notice of revocation to the attention of the Health Information Management Department (HIM) at the address listed above. The revocation will be effective i upon HIM's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Hospital in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Hospital to use or disclose my health information in the manner described above.

× _____ _____ _____
**Signature of Patient or Legal Representative of Patient** **Date** **Signature of Witness or Employee**

# Change in Attending Physician Designation

Hospice's Name: Amerihealth Group Inc DBA Ameri Hospice

Patient's Name: _____

My current Attending Physician is:

Full Name: _____

Office Address: _____

NPI number: _____

I request a change in my designated Attending Physician to:

Full Name: Bilal Mustafa,MD

Office Address: 4809 Mulholland Dr,Plano,Tx 75074

NPI number: 1356661185

The effective date of change in designation is _____.

I am making this request of my own free will and have not been coerced, solicited, or pressured by anyone to do so.

_____ _____
Patient Signature Date

X _____ _____
Patient's Authorized Representative Date

_____ _____
Hospice Representative Date

❑ Copy sent to current attending physician.

❑ Copy sent to newly designated attending physician

# Wound Photography Consent

I, _____ hereby consent and so authorize the taking
(Name of Patient)

of photographs by a representative of the Hospice. I understand that all photographs taken will be used solely for purposes of medical information and that they will be treated and handled in a confidential manner. Further, I understand that I may request possession of the photographs or that they be destroyed at any time.

I further hereby release the Hospice and its personnel from any and all liability in the taking and use of these photographs. I also understand that these photographs may be submitted upon request to insurance companies, Medicare or Medicaid, and other payors of care.

This consent is entered into on the following date: _____

X _____ _____

Patient or Authorized Representative Signature | Relationship, if other than patient

_____ _____

Witness Signature | Date/Time

**Figure: 25 TAC §157.25 (h)(2)**

# OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

## TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Print Form

STOP DO NOT RESUSCITATE

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

**A. Declaration of the adult person:** I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

**B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:**

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

**C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication:** I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature X _____ Date _____ Printed name _____

**D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person:** I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

**I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic # _____

**E. Declaration on behalf of the minor person:** I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

**TWO WITNESSES:** (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

**Notary in the State of Texas and County of** _____. The above noted person personally appeared before me and signed the above noted declaration on this date _____.

Signature & seal: _____ Notary's printed name _____ *Notary Seal*

**[ Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner ]**

**PHYSICIAN'S STATEMENT:** I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

**F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative:** The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

**All persons who have signed above must sign below, acknowledging that this document has been properly completed.**

Person's signature _____ Guardian/Agent/Proxy/Relative signature X _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

***This document or a copy thereof must accompany the person during his/her medical transport.***

# INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

**PURPOSE:** The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.
**APPLICABILITY:** This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.
**IMPLEMENTATION:** A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:
**Section A** - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.
**Section B** - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.
**Section C** - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.
**Section D -** If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.
**Section E** - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.
**Section F** - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is a representative of the ethics or medical committee of the health care facility in which the person is a patient.
**In addition**, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.
**REVOCATION:** An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.
**AUTOMATIC REVOCATION:** An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

## DEFINITIONS

**Attending Physician:** A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state**.** [HSC §166.002(12)].
**Health Care Professional:** Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]
**Qualified Relative:** A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.
**Qualified Witnesses:** Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.
***Report problems with this form to the Texas Department of State Health Services (DSHS)*** or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

*Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC§166.011*