AREA AGENCY ON AGING OF DEEP EAST TEXAS
CAREGIVER INTAKE

The information on this form is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Department of Aging and Disability Services. All information provided will be kept confidential and guarded against unofficial use. Information gathered through an intake or through an assessment may be shared to effectively plan, arrange and deliver services to meet individual client needs.

Release of information has been clearly explained to the client. ☐

Client's Primary Language: _____

Date: _____ **Client ID Number:** _____

Last Name: _____ **MI:** _____ **First Name:** _____

Street Address/Apt. #: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Phone: (____) _____ **Gender: Male** ☐ **Female** ☐ **Birth Date:** _____

Ethnicity (Check One):

- **(1) Hispanic or Latino** ☐
- **(2) Not Hispanic or Latino** ☐
- **(3) Ethnicity Not Reported** ☐

Race (Check all that apply):

- **(1) White – Non Hispanic** ☐
- **(2) White – Hispanic** ☐
- **(3) American Indian/Alaska Native** ☐
- **(4) Asian** ☐
- **(5) Black or African American** ☐
- **(6) Native Hawaiian or Pacific Islander** ☐
- **(7) Persons Reporting Some Other Race** ☐
- **(8) Race Not Reported** ☐

Marital Status (Check One):

- (1) Married ☐
- (2) Widowed ☐
- (3) Divorced ☐
- (4) Separated ☐
- (5) Never Married ☐
- (6) Not Reported ☐

Relationship to Care Recipient(s) (Care Recipient must be 60 years of age or older):

☐ **Husband** ☐ **Wife** ☐ **Son/Son-in-Law** ☐ **Daughter/Daughter-in-Law**

☐ **Other Relative** ☐ **Non-Relative** ☐ **Relationship Missing**

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Relationship to Care Recipient(s) if 18 Years of Age or Less (Caregiver must be 55+ years of age and fall under OAA, Section 372 as defined):

☐ **Grandparents** ☐ **Other Elderly Relative** ☐ **Other Elderly Non-Relative**

- Does the Caregiver live with the Care recipient? ☐ Yes ☐ No
- If no, how often does the Caregiver have contact with the Care Recipient? _____

CARE RECIPIENT PROFILE

Language spoken at home: _____ Does the Care Recipient require an interpreter? ☐Yes ☐ No

If yes, who helps in the interpretation? _____

- If care recipient is 60 years of age or older complete the following:

Date: _____ **Client ID Number:** _____

Last Name: _____ MI: _____ First Name:: _____

Street Address/Apt. #: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: (____) _____ Gender: Male ☐ Female ☐ **Birth Date**: _____

Ethnicity (Check One):		Race (Check all that apply):		Marital Status (Check One):	
(1) Hispanic or Latino	☐	(1) White Non Hispanic,	☐	(1) Married	☐
(2) Not Hispanic or Latino	☐	(2) White – Hispanic	☐	(2) Widowed	☐
(3) Ethnicity Not Reported	☐	(3) American Indian/Alaska Native	☐	(3) Divorced	☐
		(4) Asian	☐	(4) Separated	☐
		(5) Black or African American	☐	(5) Never Married	☐
		(6) Native Hawaiian/Other Pacific Islander	☐	(6) Not Reported	☐
		(7) Persons Reporting Some Other Race	☐		
		(8) Race Not Reported	☐		

Monthly Household Income: $_____ Low Income ☐ Moderate Income ☐ High Income ☐

{Low Income Levels for: Single person family unit – $ 11,490; Two person family unit – $15,510; Add $4,020 for each additional person}

Area Agency on Aging

Area Agency on Aging of Deep East Texas

Client Information Release

Client Name:	Client ID:

By signing this authorization, you are giving the Area Agency on Aging (AAA) Deep East Texas_ permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the AAA. This release includes access to a continuum of service(s) available through the AAA or its providers.

PARTS A, B & C TO BE COMPLETED BY CLIENT OR PERSONAL REPRESENTATIVE

I authorize the Area Agency on Aging to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

PART A – Release of Information

I understand that my information may contain protected health information. Release my information to the following person or agency: ☐ Any person or agency necessary to meet my service needs.

☐ Only the persons or entities identified:

Check one of the following: ☐ Release all of my information. ☐ Release only the following information:

PART B – Purpose of Release

☐ General: To assist in assessing, arranging, and meeting individual service needs.

☐ Specific:

☐ Expiration: This authorization expires at point of reassessment, where applicable, or within three years of effective date.

PART C – Signature

(Client or Personal Representative)	(Date)

☐ Check if you are signing for the client and please describe your authority to act for the client on the following line:

Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the client file.

Witness:	Date:
Witness:	Date:

Notice to Client:

- ✓ Once the authorization to release your information is granted, the AAA is not responsible for any redisclosure of the information by the recipient.
- ✓ You can withdraw permission you have given the AAA to use or disclose health information that identifies you, unless the AAA has already taken action based on your permission. You must withdraw your permission in writing.

Area Agency on Aging

Area Agency on Aging of Deep East Texas

Client Rights & Responsibilities and Release of Information for Older Americans Act Programs

The Area Agency on Aging of Deep East Texas welcomes you to our programs, made available to you through the Older Americans Act of 1965. These programs and a variety of services are administered by the Area Agency on Aging with funding provided through the Texas Department of Aging and Disability Services, client contributions and local funding.

Programs and services are designed for people who age 60 or older, their family members, and other caregivers. Our goal is to help older people lead independent, meaningful and dignified lives in their own homes and communities as long as possible. Our program supports that goal by providing limited support services and by assisting you in finding answers when you want help. Your information will not be released to anyone, or any agency without your informed consent, with the exception of records subpoenaed by a court of law.

Release of Information:
Information we gather through an intake or through an assessment may be shared to plan, arrange and deliver services to meet your individual client needs. The information collected is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Department of Aging and Disability Services. All of your information will be kept confidential and guarded against unofficial use.

Client rights and responsibilities:

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.
2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and/or unwillingness to contribute.
3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance contact the Area Agency on Aging. Contact information is identified below:

Service Provider Information	Area Agency on Aging Information
Donna Sprouse	Holly Anderson
Area Agency on Aging of Deep East Tx	Area Agency on Aging of Deep East Tx
210 Premier Drive	210 Premier Drive
Jasper, Texas 75951	Jasper, Texas 75951
409-381-5255	409-384-7614
	2-1-1

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Revision Date: 2/10/15

4. You have the right to participate in the development of a care plan to address unmet needs (If Applicable).
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding (If Applicable).
6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available, and change service providers when desired (If Applicable).
7. You have the right to be informed of any change in service(s).
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if you are unable or choose not to make a contribution. All contributions are confidential and are used only to expand or enhance the service(s) for which a contribution was provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when you will not be using services.
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

I hold harmless this Area Agency on Aging program, its parent organization, funders, and the sponsoring state agencies for any liability arising out of the services provided in accordance with program guidelines.

_____ _____

Print Client Name Date

_____

Client Signature

Funded by the Texas Department of Aging and Disability Services

Form#AIAAA_CR&R4.0 Revision Date: 2/10/15

Nacogdoches Treatment Center
Day Activity Program

Consent Form

Client Name_____

I certify that I am the primary caregiver (legal guardian) of the above-named person, and I give permission to participate in the day activity program for Alzheimer's and person's with related dementias program at the Nacogdoches Treatment Center.

Field Trips

____ I agree to allow my family member to participate in the Nacogdoches Treatment Center's sponsored field trips during the regular day's activities. I understand the group will travel by the van owned by the Nacogdoches Treatment Center, or by a personal automobile.

I understand the Executive Director, the paid workers, or the volunteer will not be held liable for any accident, injury or illness that might occur.

__ I do not agree to allow my family member to participate in field trips sponsored by the Nacogdoches Treatment Center.

Photographs

____ I do consent to photographs or videos being taken by or for the Nacogdoches Treatment Center. I understand that the photography / videos may be distributed and used for an undetermined length of time in the future. Therefore, if I revoke the consent, the Nacogdoches Treatment Center will not be held responsible for photographs used that already has been placed in the stream of public viewing.

___ I do not consent any photos or videos to be taken for or by the Nacogdoches Treatment Center.

_____

Signature of Caregiver

Background Information

Participant's Name_____ DOB___/___/___

Living Locations:
Place of Birth_____
Raised_____
Other places lived_____
Lives now_____
Family: Parents names_____
Brothers and Sisters_____
Spouse and children_____
Any other friend or relative significant to them_____
_____

Religious Preference:_____

Highest Education Achievement:_____

Military Services ___ yes ___no___ Branch_____ Years served_____

Work History:
Occupation _____Volunteer/ community services _____

General Information:
Which would best describe their conversational style: quite____ moderate____ talkative____

In conversation do they imitate_____ respond only_____ (say yes or no) fail to express complete thoughts_____ loses topics_____

Describe their eating habits: (i.e. feeds self, problem with choking, finger food needed, amount of food usually eaten) _____
_____

Describe their mobility: (i.e. walks alone, uses cane, walker, physical assistance needed, wanders, redirects easily or with difficulty)
_____
_____

Check all that apply to their behavior:

Agitates easily
Quarrelsome
Affectionate
Depressed
Sometimes sits with head down
Cooperative
Disruptive
Withdrawn
Suspicious

Sense of humor
Flirtatious
Paces
Wanders
Sees/hears things that are not there
Reliable with what he/she says
Verbally aggressive
Physically aggressive

Additional comments:

_____

_____

We would like to know their favorite in the following areas:

Foods_____
Colors_____
Music_____
Hobbies_____
Reading Materials_____
Crafts_____
T.V. programs_____
Movies_____
Sports_____
Fitness/exercise_____

Do they like: Word games_____ crossword puzzles_____ card games_____
Dominoes_____

Do they enjoy gardening? _____

What size group are they most comfortable in: small_____ medium_____ large_____

Nacogdoches Treatment Center
Respite Weekend
Release

As the caregiver for _____ I give my permission for him/her to stay at the Nacogdoches Treatment Center for Respite Weekend Care. The staff at the Nacogdoches Treatment Center is willing to provide this opportunity for their clients involved in the Day Activity Program. I understand there are added risks involved in keeping clients for 48 hours.

I understand that if medications must be administered during the weekend, it will be given by the staff members of the Nacogdoches Treatment Center who have no formal medical training. I will prepare the necessary medications for my loved ones with the written instructions on how they are to be administered for the staff to follow. I understand the risk in medication being administered by a non-licensed medical professional and I do not hold the Nacogdoches Treatment Center responsible if the medications are not administered correctly.

☐ Administer medications ☐ Do not administer medications

I understand that clients will be given the opportunity for baths during their stay over the weekend. I understand that there is an added risk of accident, namely falling during bathing. If I choose to have my loved one bathed, I accept the risk involved and do not hold the Nacogdoches Treatment Center responsible for any accident that may occur

☐ Bath ☐ Do not bath

I understand the clients may leave the facility and go on an outing with the staff during the weekend stay. I give permission for my loved one to participate in these outings. I understand the added risk in taking the clients from the facility and do not hold the Nacogdoches Treatment Center responsible for any accident that may occur outside the facility.

☐ Allow to leave the facility

I understand that if an emergency occurs that the staff will try and contact me at the phone number listed on this form. If I cannot be reached, the staff will call 911 and have the ambulance service come and take the client to the emergency room at the hospital listed on the emergency form in the clients Day Activity program folder. The emergency folder will be given to the emergency responders. I do not hold the Nacogdoches Treatment Center responsible for any accidents that may occur.

I have read the above release form and accept the terms of this agreement.

_____ _____

Name Phone number

_____ _____

Staff Signature Date

Nacogdoches Treatment Center
Van Policy

1. Seating is available by first request.
2. Each rider must be able to sit in the seat with seatbelt on
3. The rider must be able to ride without causing a distraction to the driver
4. Driver will assist with loading and unloading and securing seatbelts. The driver is not responsible for the rider before or after they step on or off the van.
5. Transportation is provided with in the city limits. It is limited to passable roadways that will accommodate the size of the van safely when meeting on-coming traffic.
6. The route of the van will change as riders are added or dismissed. Exact times for pick up and drop off will change as riders change. It is important that all riders be ready by 9:00 am so when the driver gets to your residence you are ready. The driver cannot wait more than 3 minutes for the rider to come out and load onto the van. (if the driver waits more than 3 minutes on each of the11 riders that would add another 33 minutes to the route) If the rider is not ready at that time the family will be responsible for bringing them to the center.
7. If a rider is delivered home and there is no one there the driver will bring the rider back to the Treatment Center and the family will be responsible to come and pick them up by 4pm. If the rider is to be left home alone the family must notify the Treatment Center in writing that you request that arrangement.
8. Riders will be allowed to use assistive devices on the ban. Persons who use wheelchairs will be loaded and chairs will be secured using appropriate devices. Persons using walkers and canes will give those devices to the driver to be stored at the front of the van.

I have read and understand the above rules. I understand the failure to follow these rules will result in this service being denied.

_____ _____

Rider (if able to sign) Date

_____ _____

Legal Caretaker Date

Nacogdoches Treatment Center Emergency Policy

If a Medical Emergency arises with a client, the Nacogdoches Treatment Center staff will try to contact the person listed on the Emergency Contact Information Form.

If the Nacogdoches Treatment Center is unable to reach the Emergency Contact Person listed an ambulance will be called and the client will be transported to the Emergency room.

Nacogdoches Treatment Center staff will not be responsible to go with the client to the Emergency room. The Emergency Contact Information Form, List of Medication Form and the Advance Directive Form will be given to the EMT's to accompany the client to the hospital.

I have read and understand the information above

_____	_____
Client	Date
_____	_____
Legal Caretaker	Date

Emergency Information Form

Client Name_____

Date of Birth _____Age _____Sex_____

Insurance Information_____

_____

Physicians Name _____Phone#_____

Emergency Contact_____Relationship_____

Phone Numbers_____

If Caregiver is not available,

Contact:_____Phone#_____Work#_____

Cell#_____ Relationship to Client:_____

Hospital Preference_____

Medical Conditions _____

Medications: Dose and Frequency

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies_____

Glasses_____ Dentures _____Hearing Aides_____

Height _____Weight_____ Build_____

Hair Color_____ Eye Color_____ Skin tone_____

Other identifying features:_____

DNR in place Yes_____ No_____

Figure: 25 TAC §157.25 (h)(2)

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

Print form

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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 _____ 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 _____

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

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

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