

# THE DURAN FIRM, PLLC



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## RECEIPT AND COMPLETION OF THIS DOCUMENT DOES NOT ESTABLISH AN ATTORNEY-CLIENT RELATIONSHIP

Via Download

To: Prospective Clients

Re: Prospective Client Information Worksheet for Living Will

Dear Prospective Clients,

Thank you for contacting The Duran Firm regarding the preparation of your Living Will. In order to start work on your Living Will, I need some information about you and your wishes in the event you are expected to die without life sustaining medical treatment. By completing the attached Worksheet and sending it to The Duran Firm, you make it possible for The Duran Firm to have a draft of your Living Will ready for discussion at our initial meeting.

Please understand that the receipt of this Worksheet by The Duran Firm does not establish an attorney-client relationship. The Duran Firm will require pre-payment of its fees and the execution of an attorney-client fee agreement prior to accepting you as a client. We do, however, look forward to working for you.

Please contact me if you have any questions.

Sincerely,

Michael A. Duran

Attachment

# THE DURAN FIRM, PLLC

## Client Information Worksheet

### I. General Client Information.

#### A. Prospective Client

1. Formal Name: \_\_\_\_\_  
First Middle Last
2. Aliases: \_\_\_\_\_
3. Address: \_\_\_\_\_  
Street Apt #  
\_\_\_\_\_  
City County State Zip Code
4. Phone Number: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work
5. Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
6. U.S. Citizen: Yes  No

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## III. Planning for Your Incapacity

### A. Living Will or Directive to Physicians

A Living Will, also known as an “Advance Directive” or “Directive to Physicians” is a document that 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.

#### 1. Prospective Client

a. 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 (CHOOSE ONE):

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.)

b. 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 (CHOOSE ONE):

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.)

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

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## CERTIFICATION STATEMENT (REQUIRED)

I certify that the information provided in this Client Information Worksheet is true and correct and in accordance with my wishes.

SIGNED this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_\_.

\_\_\_\_\_  
Prospective Client