

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

**Physician Orders for Life-Sustaining Treatment
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This is a Physician Order Sheet/Living Will, covering certain medical interventions that are typically administered in "End of Life" situations. The order reflects the agreement between both the attending physician and the patient or, if the patient is now incompetent, his/her Substitute Decision Maker (SDM).

Any section not completed implies full treatment for the section to the extent it is medically indicated. In case of an emergency, follow this form first; then contact the physician.

Initials of patient/Substitute Decision Maker required on applicable lines.

Name of Patient/Resident

Name of Physician

Section A	<p>RESUSCITATION: Patient/resident has no pulse and/or is not breathing.</p> <p><input type="checkbox"/> Resuscitate <input type="checkbox"/> Do Not Resuscitate (DNR)</p> <p>When not in cardiopulmonary arrest, follow orders in Sections B, C and D.</p>
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Section B	<p>MEDICAL INTERVENTIONS: Patient/resident has pulse and is breathing.</p> <p><input type="checkbox"/> Comfort Measures Only. The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives</p> <p>Hospitalization.</p> <p><input type="checkbox"/> Do not hospitalize if comfort measures fail. <input type="checkbox"/> Hospitalize if comfort measures fail.</p> <p><input type="checkbox"/> Limited Additional Interventions. Includes all comfort measures as listed above, including transfer to hospital, if indicated, cardiac monitoring, and any interventions checked in Section C or D. No endotracheal intubation or ventilation, cardioversion or long-term life support measures will be given.</p> <p><input type="checkbox"/> Full Treatment. Includes care above plus endotracheal intubation, ventilation and cardioversion, if indicated.</p> <p><i>Additional Instructions:</i> _____</p>
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Section C	<p>ANTIBIOTICS: Comfort measures are always provided.</p> <p><input type="checkbox"/> No antibiotics <input type="checkbox"/> Antibiotics</p> <p><i>Additional Instructions:</i> _____</p>
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Section D	<p>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: Comfort measures are always provided.</p> <p><input type="checkbox"/> No feeding tube <input type="checkbox"/> No IV fluids</p> <p><input type="checkbox"/> Defined trial period of feeding tube <input type="checkbox"/> Defined trial period of IV fluids</p> <p><input type="checkbox"/> Long term feeding tube <i>Additional Instructions:</i> _____</p>
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Section E	<p>Discussed with:</p> <p><input type="checkbox"/> Patient/ <input type="checkbox"/> Resident <input type="checkbox"/> Parent of <input type="checkbox"/> Minor <input type="checkbox"/> Power Of <input type="checkbox"/> Attorney <input type="checkbox"/> Court- <input type="checkbox"/> Appointed <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____</p>	<p>Patient/Resident (Parent of Minor Child) Preferences as a Guide for this Form</p> <p>I have given significant thought to life-sustaining treatment. I expressed my preferences to my physician and/or health care provider(s). This document reflects my treatment preferences.</p> <ul style="list-style-type: none"> • Patient is competent • Patient is incompetent and a SDM has the authority to consent on behalf of the patient. • Appropriate documentation is attached including guardianship papers or Power of Attorney with healthcare clause. <p>_____ Signature of Person Preparing Form</p> <p>_____ Patient/SDM</p> <p>_____/_____ Preparer Name (print) Date</p> <p>_____ Witness</p>	<p>_____ Physician Signature</p>
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Name of Patient/Resident

This order is in effect/valid until one of the following situations occurs; in which case, it needs to be reviewed and, if necessary, rewritten.

Name of Physician

Section F

When This Form Should Be Reviewed

1. The patient/resident is transferred from one care setting or care level to another.
2. There is a substantial change in patient/resident health status, both improvement or deterioration.
3. The patient/resident treatment preferences change.
4. The following specific event occurs.
5. After _____ days of the authority or the last review of this form.

How to Complete the Form Review

- Review **Sections A through E**
- Complete **Section G**

If this form is to be voided, write “**VOID**” in large letters on the front of the form.
After voiding the form, a new form may be completed.
If no new form is completed, full treatment and resuscitation may be provided.

Section G

Review of this Form

		Patient or SDM Initials	Reviewer	Location of Review	Outcome of Review
					<ul style="list-style-type: none"> • No change • FORM VOIDED, new form completed • FORM VOIDED, no new form
					<ul style="list-style-type: none"> • No change • FORM VOIDED, new form completed • FORM VOIDED, no new form
					<ul style="list-style-type: none"> • No change • FORM VOIDED, new form completed • FORM VOIDED, no new form
					<ul style="list-style-type: none"> • No change • FORM VOIDED, new form completed • FORM VOIDED, no new form
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