

# Instructions on Current Life-Sustaining Treatment Options

**MUST be on the front of the active chart. MUST accompany the patient on any transfer.**

This form may be used by a patient or the patient's proxy (health care agent or surrogate) to document the goals of care and instructions about life-sustaining treatment options given the patient's **current** circumstances. The patient's attending physician or another health care provider should discuss relevant options with the patient/proxy. This is not an advance directive, but this form can be used to clarify or apply an existing advance directive. A proxy's instructions must be within the proxy's legal authority. A patient/proxy who wants to use this form should initial one instruction within the parts that are now relevant and sign the form; the health care providers should also sign it.

<b>Patient's Name:</b>	
<b>Date of Birth:</b>	

<b>Part A</b> Fill in briefly, then <i>initial</i> on the line →→→	<b>Most Important Goal(s) of Care</b> (By giving these instructions, what does the patient or proxy hope to achieve?)  _____
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<b>Part B</b> Fill in	<b>Advance Directive and Contact Information.</b> If the patient has a written advance directive, check this box <input type="checkbox"/> and <i>append copy</i> .  Provide contact information for a proxy in case the patient lacks or loses capacity.  _____ <b>Name and phone number of health care agent, if one has been named, or surrogate if not.</b>
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➔ Instructions given below should serve the main goal(s) in Part A and, if made by a proxy, must be consistent with the patient's advance directive (if any). "Other" allows for instructions that modify or change what is preprinted or to state, "No decision at this time." Do **not** initial more than one instruction per part.

<b>Part C</b> <i>Initial.</i> Do <u>not</u> "✓" or "X"	<b>Code Status</b> _____ <b>Yes, attempt cardiopulmonary resuscitation (CPR)</b> _____ <b>No, do not attempt CPR; allow death to occur naturally</b> ✎ <b>EMS/DNR Order to be issued if appropriate</b>
<b>Part D</b> <i>Initial.</i> Do <u>not</u> "✓" or "X"	<b>Artificial Ventilation</b> _____ <b>Artificial ventilation acceptable, even indefinitely</b> _____ <b>Artificial ventilation acceptable as therapeutic trial (time limit: _____)</b> _____ <b>No artificial ventilation</b> _____ <b>Other:</b>
<b>Part E</b> <i>Initial.</i> Do <u>not</u> "✓" or "X"	<b>Hospital Transfer Status</b> _____ <b>Transfer to hospital for any condition requiring hospital-level care</b> _____ <b>Transfer to hospital acceptable for evaluation of acute injury</b> _____ <b>Do not transfer; treat with options available outside the hospital</b> _____ <b>Other:</b>

<b>Part F</b> <i>Initial.</i> Do <u>not</u> “✓” or “X”	<b>Medical Workup</b> for significant and possibly treatable symptoms that could be evaluated through blood work, X-rays, etc.  _____ <b>All medical tests acceptable (treatment planned for diagnosed condition)</b> _____ <b>Limited (noninvasive, low risk) medical tests only</b> _____ <b>No medical tests</b> _____ <b>Other:</b>
<b>Part G</b> <i>Initial.</i> Do <u>not</u> “✓” or “X”	<b>Antibiotics</b>  _____ <b>Antibiotics acceptable</b> _____ <b>Antibiotics acceptable, but not by intravenous infusion</b> _____ <b>No antibiotics except if needed for comfort</b> _____ <b>Other:</b>
<b>Part H</b> <i>Initial.</i> Do <u>not</u> “✓” or “X”	<b>Artificially Administered Fluids and Nutrition</b>  _____ <b>Artificially administered fluids and nutrition acceptable, even indefinitely</b> _____ <b>Artificially administered fluids and nutrition acceptable as therapeutic trial (time limit: _____)</b> _____ <b>Intravenous fluids acceptable; no artificially administered nutrition</b> _____ <b>No artificially administered fluids and nutrition</b> _____ <b>Other:</b>
<b>Part I</b> <i>Initial.</i> Do <u>not</u> “✓” or “X”	<b>Other Life-Sustaining Treatments if Applicable (Example: blood transfusions, kidney dialysis)</b>  <b>Specify treatment:</b> _____  _____ <b>Acceptable, even indefinitely or repeatedly</b> _____ <b>Acceptable if recommended for an acute episode, but not indefinitely or repeatedly</b> _____ <b>Not acceptable</b> _____ <b>Other:</b>
<b>Name of Patient, Health Care Agent, or Surrogate (print, and circle which one)</b>  <b>Signature</b> _____ <b>Date:</b> _____	
<b>Name of Health Care Provider Assisting with Form (print)</b>  <b>Signature</b> _____ <b>Phone:</b> _____ _____ <b>Date:</b> _____	
<b>Physician Name (print)</b>  <b>Physician Signature</b> _____ <b>Phone:</b> _____ _____ <b>Date:</b> _____	

**Review:** These instructions may be reviewed at any time – a review should occur whenever:

- ✓ The patient is transferred from one care setting or care level to another or is discharged, or
- ✓ The patient’s health status changes substantially, including loss of capacity, or
- ✓ The most important goal of care or specific treatment instructions change.

**This form documents a discussion about current options.**  
**By itself, it is not a physician’s order, but should be reviewed prior to the entry of new orders.**