

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.

Patient's Name:	
Date of Birth:	

Part A Fill in briefly, then <i>initial</i> on the line →→→	Most Important Goal(s) of Care (By giving these instructions, what does the patient or proxy hope to achieve?) _____ _____
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Part B Fill in	Advance Directive and Contact Information. 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. _____ Name and phone number of health care agent, if one has been named, or surrogate if not.
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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.

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

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

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.