Instructions on Current Life-Sustaining Treatment Options

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

Patient's Name: _____

Date of Birth: _____

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.

Part A Fill in briefly, then *initial* on the line ➔➔➔	**Most Important Goal(s) of Care** (By giving these instructions, what does the patient or proxy hope to achieve?) _____

Part B Fill in	**Advance Directive and Contact Information.** If the patient has a written advance directive, check this box ❑ and ***append copy***. 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.**

➔ 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 *Initial*. Do not "✓" or "✕"	**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 *Initial*. Do not "✓" or "✕"	**Artificial Ventilation** _____ **Artificial ventilation acceptable, even indefinitely** _____ **Artificial ventilation acceptable as therapeutic trial (time limit: _____)** _____ **No artificial ventilation** _____ **Other:**
Part E *Initial*. Do not "✓" or "✕"	**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 *Initial*. Do not "✓" or "✕"	**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 *Initial*. Do not "✓" or "✕"	**Antibiotics** _____ **Antibiotics acceptable** _____ **Antibiotics acceptable, but not by intravenous infusion** _____ **No antibiotics except if needed for comfort** _____ **Other:**
Part H *Initial*. Do not "✓" or "✕"	**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 *Initial*. Do not "✓" or "✕"	**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.