This is a physician order sheet based on patient wishes and medical indications for life-sustaining treatment. Place this order in a prominently visible part of the patient’s record. Both the patient and the physician must sign this order (two physicians must sign if the patient is a minor child). When the patient’s condition makes this order applicable, first follow this order, and then, if necessary, contact the signing physician.

**Physician’s Name:**

**Physician’s Phone:**

Last Name of Patient:

First Name/Middle Initial:

Date of Birth:

Effective Date of this Order:

(If nothing in a section is checked, caregivers should provide the fullest treatment described in that section unless that treatment directly conflicts with a treatment checked in another section)

<table>
<thead>
<tr>
<th>Section A</th>
<th>Treatment options when the patient has no pulse and is not breathing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check one</td>
<td>____ Attempt to resuscitate ____ Do not attempt or continue any resuscitation (DNR)</td>
</tr>
<tr>
<td></td>
<td>Other instructions or clarification: ________________________________</td>
</tr>
<tr>
<td></td>
<td>________________________________</td>
</tr>
<tr>
<td></td>
<td>________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B</th>
<th>Treatment options when the patient has a pulse and is breathing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check one</td>
<td>____ Comfort measures only: Oral and body hygiene; reasonable efforts to offer food and fluids orally; medication, oxygen, positioning, warmth, and other measures to relieve pain and suffering. Provide privacy and respect for the dignity and humanity of the patient. <strong>Transfer to hospital only if comfort measures can no longer be effectively managed at current setting.</strong></td>
</tr>
<tr>
<td></td>
<td>____ Limited additional interventions: Includes care above. May also include suction, treatment of airway obstruction, bag-valve-mask ventilation, monitoring of cardiac rhythm, medications, IV fluids. <strong>Transfer to hospital if indicated, but no endotracheal intubation or long-term life support measures.</strong></td>
</tr>
<tr>
<td></td>
<td>Other instructions or clarification: ________________________________</td>
</tr>
<tr>
<td></td>
<td>________________________________</td>
</tr>
</tbody>
</table>

| Section C | Antibiotics: (Comfort measures are always provided) |
| Check all that apply | ____ No antibiotics |
| | ____ Antibiotics may be administered |
| | Other Instructions or clarification: ________________________________ |
| | ________________________________ |
| | ________________________________ |
Artificially administered fluid and nutrition: (Comfort measures are always provided)

Feeding Tube:
- ___ No feeding tube
- ___ Defined trial period of feeding tube
- ___ Long-term feeding tube

IV Fluids:
- ___ No IV fluids
- ___ Defined trial period of IV fluids
- ___ IV Fluids

Other Instructions or Clarification:

Section E
Check all that apply

Discussed with:
- ___ Patient / Parent(s) of Minor Child
- ___ Surrogate (source of legal authority, name, and phone number):

Other (name and phone number):

Patient preferences to guide physician in ordering life-sustaining treatment

Section F
I have given significant thought to life-sustaining treatment. Please see the following for more information about my preferences:

Advance Directive: ___ no ___ yes

Other:

I have expressed my preferences to my physician or health care provider(s) and agree with the treatment order on this document. Please review these orders if there is a substantial permanent change in my health status, such as:

- Close to death
- Advance progressive illness
- Improved condition
- Permanently unconscious
- Extraordinary suffering
- Surgical procedures

Brief summary of medical condition and brief explanation of treatment choice:

Signature of person preparing form (if not patient's physician)

Print name and phone number

Date prepared:

Signature of physician or other licensed practitioner

Print name and license number

Date signed:

Signature of second physician or other licensed practitioner (required for minor patients only)

Print name and license number

Date signed:

Patient, Parent, or Surrogate signature

Print name and phone number

Date signed:

Review and Change to Life with Dignity Order

Review this form whenever any of the following happen:
1. The patient is transferred from one care setting to another;
2. The patient’s health status changes substantially and permanently; or
3. The patient’s treatment preferences change.

If the patient or the patient’s surrogate changes the treatment preferences in this order, complete a new form and place it in the patient’s medical record. This form is valid for both adult and pediatric patients.

A COPY OF THIS FORM MUST ACCOMPANY THE PATIENT WHEN TRANSFERRED OR DISCHARGED
(INCLUDING TRANSFERS TO HOSPITAL EMERGENCY DEPARTMENTS)