## ADVANCE DIRECTIVE / PREFERRED INTENSITY OF CARE DOCUMENTATION

## SECTION I ADVANCE DIRECTIVE DOCUMENTATION

	nformation from le	gal dod	cume	nts complete	d prior to admissio	n. Atta	ch copy	of docur	nent)
RESUSCITATE:	NO	YES		Т	UBE FEEDING:	NO		YES	
RESTRICTION ON N	MEDICATION:	YES NO		SPECIFY RE	STRICTIONS				
RESTRICTION ON T	FREATMENT:	YES NO		SPECIFY RE	ESTRICTIONS				<del></del>
OTHER DIRECTIVE	S/REQUESTS (S	PECIFY	/ i.e. C	ORGAN DONA	ATION):				
Appointed Surrogate Initial all statements I If an emergency exis disability or alleviate  I desire you	below and answer, sts where there is a	n unant in, you	ticipate will be	ed condition in contacted an					
treatment(s)  I understand	after being informe	d of risl	ks or d	consequences ctive can be cl	d and that I have the by the physician. hanged and modified				
Resid	lent / Surrogate		-	Date	Facility Repre	sentati	ve - Title		
									î.
SECTION	ON II PREF		_		OF CARE DO	CUN	MENTA	TION	
		1980	eterm	1577 ID	ble resident*)				
RESUSCITATE:	NO L	YES			UBE FEEDING:	NO		YES	
RESTRICTION ON N	MEDICATION:	YES		SPECIFY RE	STRICTIONS				
TILOTHON ON I	VILDICATION.	NO							
RESTRICTION ON T				SPECIFY RE	ESTRICTIONS				
	FREATMENT:	NO YES NO	☐ ☐ ☐ TANO		ESTRICTIONS				
OTHER REQUESTS Initial all statements I If an emergency exis disability or alleviate	FREATMENT:  (SPECIFY i.e. OR below and answer, sts where there is a severe physical pa	NO YES NO GAN Do as appoint unant in, you	ropriaticipate	TION):te: ed condition ir contacted an	which immediate a	ordanc	e with ph		
RESTRICTION ON TO THER REQUESTS Initial all statements If an emergency exist disability or alleviate  I desire your landerstand treatment(s) I understand	CREATMENT:  (SPECIFY i.e. OR below and answer, sts where there is a severe physical parto execute the "Presentation of the treatment after being informed)	NO YES NO GAN Do as apport nunant in, you we ferred limit option d of risk eferred	ropriaticipate will be ntensions makes or continued to the continued to th	TION): te: ed condition in contacted an ty of Care Dec y be presente consequences	n which immediate and action taken in according as indicated and that I have the	ordanc above. right to	e with ph	ysician o	erders.
RESTRICTION ON TO THER REQUESTS Initial all statements If an emergency exist disability or alleviate  I desire your landerstand treatment(s) I understand	CORECTED I.e. OR below and answer, sts where there is a severe physical parto execute the "Pred that other treatment after being informed that the above "Pred that the above "Pred that other treatment after being informed that the above "Pred that other treatment after being informed that the above "Pred that other treatment after being informed that the above "Pred that other treatment after being informed that the above "Pred that the above "Pred that the above "Pred that the above "Pred the above "Pred that the above "Pred the above	NO YES NO GAN Do as apport nunant in, you we ferred limit option d of risk eferred	ropriaticipate will be ntensins makes or contensins fi.	TION): te: ed condition in contacted an ty of Care Dec y be presente consequences	n which immediate and action taken in accisions" as indicated and that I have the by the physician.	ordanc above. right to	e with ph	ysician o	orders. e medical
OTHER REQUESTS Initial all statements I If an emergency exis disability or alleviate  I desire your I understand treatment(s) I understand notification to	CORECTED I.e. OR below and answer, sts where there is a severe physical parto execute the "Pred that other treatment after being informed that the above "Pred that the above "Pred that other treatment after being informed that the above "Pred that other treatment after being informed that the above "Pred that other treatment after being informed that the above "Pred that other treatment after being informed that the above "Pred that the above "Pred that the above "Pred that the above "Pred the above "Pred that the above "Pred the above	NO YES NO GAN Do as apport nunant in, you we ferred limit option d of risk eferred	ropriaticipate will be ntensins makes or contensins fi.	te: ed condition ir contacted an ty of Care Dec y be presente consequences sity of Care De	n which immediate and action taken in accisions" as indicated and that I have the by the physician.	ordanc above. right to nged ar	e with ph	ysician o	orders. e medical
OTHER REQUESTS Initial all statements I If an emergency exis disability or alleviate  I desire your I understand treatment(s) I understand notification to	CREATMENT:  S (SPECIFY i.e. OR below and answer, sts where there is a severe physical parto execute the "President other treatment after being informed that the above "President and factor physician and factor physician and factor of the second in the se	NO YES NO GAN Do as appoint unant in, your ferred lift of of risk eferred illity staf	ropriaticipate will be ntensins makes or contensif.	te: ed condition ir contacted an ty of Care Dec y be presente consequences sity of Care De	n which immediate and action taken in according as indicated and that I have the by the physician. ecisions" can be characteristically recording the present the control of the physician and the control of the physician and the characteristic forms are control of the physician and the control of the physician and the control of the physician and the physician are control of the	ordanc above. right to nged ar	e with ph	ysician o	orders. e medical

## SECTION III PREFERRED INTENSITY OF CARE DOCUMENTATION

To be completed *only* when resident *lacks capability\** for independent decisionmaking and *no prior Advance Directive* documents available

In the absence of the resident's written treatment instructions, the surrogate decisionmaker(s) have related the resident's stated preferences for intensity of treatment:

Describe resident preference regarding treatment (including approximate dates / circumstances surrounding the resident's expressions of PREFERRED intensity of treatment). Attach any other documentation which would provide information concerning the resident's desires. This section must be completed with historical rationale before the decisions below are made: Check below as it reflects the resident's expressions of Preferred Intensity of Treatment. RESUSCITATE: NO YES TUBE FEEDING: NO [ YES | RESTRICTION ON MEDICATION: YES SPECIFY RESTRICTIONS NO RESTRICTION ON TREATMENT: YES SPECIFY RESTRICTIONS NO CTHER REQUESTS (SPECIFY i.e. ORGAN DONATION): Initial all statements below and answer, as appropriate: If an emergency exists where there is an unanticipated condition in which immediate action is necessary to prevent serious disability or alleviate severe physical pain, you will be contacted and action taken in accordance with physician orders. I desire you to execute the "Preferred Intensity of Care Decisions" as indicated above. I understand that other treatment options may be presented and that I have the right to consent or refuse medical treatment(s) after being informed of risks or consequences by the physician. I understand that the above "Preferred Intensity of Care Decisions" can be changed and modified at any time upon notification to physician and facility staff. Relationship to Resident Surrogate Decisionmaker (Signature) Relationship to Resident \_\_\_\_\_ Surrogate Decisionmaker (Signature) Date Facility Representative - Title \*see physician assessment on physician admission orders/progress notes

INIT.

ATTENDING PHYSICIAN

ROOM NO

RESIDENT NUMBER

LAST NAME

FIRST NAME