Physician Orders
for Life-Sustaining Treatment

This is a physician order sheet based on patient/resident wishes and medical indications for life-sustaining treatment. If in the clinical record, this should be first page. In other settings, locate in a prominent place. When need occurs, first follow these orders, then contact physician. Any section not completed indicates full treatment.

Last Name of Patient/Resident
First Name/Middle Initial of Patient/Resident
Patient/Resident Date of Birth

Section A *Check One Box Only*

Resuscitation. Patient/resident has no pulse and is not breathing. For all other medical circumstances, refer to "Section B, Emergency Medical Services (EMS)" listed below.

☐ Resuscitate ☐ Do Not Resuscitate (DNR)

Section B *Check One Box Only*

Emergency Medical Services (EMS)

☐ **Comfort Measures Only**: Oral and body hygiene, reasonable efforts to offer food and fluids orally. Medication, positioning, warmth, appropriate lighting and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient/resident. Transfer only if comfort measures fail.

Call 9-1-1/code only if EMS is desired:

☐ **Limited Interventions**: All care above and consider oxygen, suction, treatment of airway obstruction (manual only), wound care.

☐ **Advanced Interventions**: All care above and consider oral/nasal airway, bag-mask/demand valve, monitor cardiac rhythm, medication, IV fluids.

☐ **Full Treatment**: All care above plus CPR, intubation and defibrillation.

Other Instructions: _____

Section C *Check One Box Only*

Antibiotics

☐ No antibiotics except if needed for comfort
☐ No invasive (IM/IV) antibiotics
☐ Full Treatment

Other Instructions: _____

Section D *Check One Box Only*

Artificially Administered Fluids and Nutrition (oral fluids and nutrition must be offered if medically feasible)

☐ No feeding tube/IV fluids (provide other measures to assure comfort)
☐ No long term feeding tube/IV fluids (provide other measures to assure comfort)
☐ Full Treatment

Other Instructions: _____

Section E

Discussed with: ☐ Patient/Resident ☐ Health Care Representative ☐ Court-appointed Guardian
☐ Other (specify): _____

THE BASIS FOR THESE ORDERS IS:

Signature of Physician (**mandatory**)	Physician Name (type or print)	Time and Date Signed

ORIGINAL FORM SHOULD ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED.

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How to Change "Physician Orders for Life-Sustaining Treatment"

This form, "Physician Orders for Life-Sustaining Treatment," should be reviewed if:

(1) The patient/resident is transferred from one care setting to another, or
(2) There is substantial permanent change in patient/resident health status, or
(3) The patient/resident treatment preferences change.

First, review "Patient/Resident Preferences as a Guide for Physician Orders for Life-Sustaining Treatment" (**Section F**). Second, record the review in "Review of Physician Orders for Life-Sustaining Treatment" (**Section G**).

Finally, if this form is to be voided, draw a line through the "Physician Orders" and/or write the word "VOID" in large letters, then sign or initial the form. After voiding the form, a new form may be completed. *If no new form is completed, full treatment may be provided.*

Section F **Patient/Resident Preferences as a Guide for Physician Orders for Life-Sustaining Treatment**

I have given significant thought to life-sustaining treatment. The following have further information regarding my preferences:

Advance Directive ☐ NO ☐ YES - Attach copy

Court-appointed Guardian ☐ NO ☐ YES - Attach copy of documentation

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

Close to death
Permanently unconscious
Advanced progressive illness
Extraordinary suffering

Signature of Patient/Resident or Guardian/Health Care Representative (optional)		
Signature of Person Preparing Form (optional)	**Preparer Name (type or print)**	**Time and Date Prepared**

Section G **Review of Physician Orders for Life-Sustaining Treatment**

Date of Review	Reviewer	Location of Review	Outcome of Review
			☐ No change ☐ Changed, FORM VOIDED, new form completed ☐ Changed, FORM VOIDED, ***no*** new form
			☐ No change ☐ Changed, FORM VOIDED, new form completed ☐ Changed, FORM VOIDED, ***no*** new form
			☐ No change ☐ Changed, FORM VOIDED, new form completed ☐ Changed, FORM VOIDED, ***no*** new form