Form 100-5
Rev 1.0
Series July 2016

TRANSCARE EMERGENCY MEDICAL SERVICES
ADVANCE DIRECTIVES ON LEVEL OF CARE

PATIENT'S GENERAL INFORMATION

NAME: _____ _____ _____
(LAST) (FIRST) (MIDDLE)
AGE:_____ SEX:_____ BIRTHDAY(mm/dd/yyyy):_____
ADDRESS:_____
CITIZENSHIP:_____ CONTACT NO:_____

NEXT OF KIN/LEGAL GUARDIAN INFORMATION

NAME:_____
RELATION:_____CONTACT NO:_____
ADDRESS:_____

MEDICAL RECORD #

DATE ACCOMPLISHED

YES/NO	PREFERRED LEVEL OF CARE	DESCRIPTION OF CARE
	CARDIOPULMONARY RESUSCITATION	
	ATTEMPT RESUSCITATION/CPR	May be done if a person has no pulse and is not breathing to prolong the life of the patient. This procedure entails pushing on the chest with great force and used of IV medications in attempt to restart the heart.
	MEDICAL INTERVENTION	
	COMFORT MEASURES ONLY No hospitalization unless revoked	Relieve pain and suffering through the use of medication by non-invasive route, positioning, wound care and other conservative treatment.
	LIMITED ADDITIONAL INTERVENTIONS Specify allowed interventions: ○ IV Fluid therapy ○ Nasogastric tube feeding ○ Gastrostomy tube feeding ○ Use of CPAP/BIPAP ○ Antibiotics therapy ○ Laboratory work up ○ Diagnostic work up	In addition to care described in Comfort Measures Only, use medical treatment as indicated. DO NOT intubate. May transfer to hospital ONLY if care is not met in current location.
	FULL TREATMENT	In addition to above mentioned care, use of intubation, advanced airway intervention, mechanical ventilation, defibrillation/cardioversion as indicated. TRANSFER TO HOSPITAL if indicated.
	ADDITIONAL ORDERS	

INFORMATION DISCUSSED WITH:

Patient(has capacity for decision-making) Next of kin or legally recognized decision-maker

DECISION-MAKER VERIFICATION

NAME:	RELATION: (WRITE SELF IF PATIENT)
SIGNATURE:	DATE SIGNED:

PHYSICIAN VERIFICATION

NAME:	PRC LICENSE NUMBER:
SIGNATURE:	DATE SIGNED: