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:
SIGNATURE:	DATE SIGNED:

PHYSICIAN VERIFICATION

NAME:	PRC LICENSE NUMBER:
SIGNATURE:	DATE SIGNED: