Utah Department of Health
Bureau of Health Facility Licensing, Certification and Resident Assessment

Physician Order for Life Sustaining Treatment

Utah Life with Dignity Order

Version 2 – 9/09

State of Utah Rule R432-31
(http://health.utah.gov/hflcra/forms.php)

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*)

Section A Check one	**Treatment options when the patient <u>has no pulse and is not breathing</u>:** ___ **Attempt to resuscitate** ____ **Do not attempt or continue any resuscitation (DNR)** Other instructions or clarification:_____ _____ _____
Section B Check one	**Treatment options when the patient <u>has a pulse and is breathing</u>**: ___ **<u>Comfort measures only</u>:** 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. **Transfer to hospital only if comfort measures can no longer be effectively managed at current setting**. ___ **<u>Limited additional interventions:</u>** Includes care above. May also include suction, treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, medications, IV fluids. **Transfer to hospital if indicated, but no endotracheal intubation or long-term life support measures.** Other instructions or clarification:_____ _____ ___ **<u>Full treatment</u>:** Includes all care above plus endotracheal intubation, defibrillation/cardioversion, and any other life sustaining care required. If necessary, transfer to (hospital name): _____ Other Instructions or clarification:_____ _____ _____
Section C Check all that apply	**Antibiotics:** (**Comfort measures are always provided)** ___ No antibiotics ___ Antibiotics may be administered Other Instructions or clarification:_____ _____

Section D Check all that apply	**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:
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)