

MAINE EMS COMFORT CARE/DO-NOT-RESUSCITATE

COMFORT CARE/DO NOT RESUSCITATE ORDER

Patient's Full Legal Name: _____

ATTENDING PHYSICIAN'S ORDER

I, the undersigned, state that I am the attending physician of the patient named above.

I have diagnosed and certified in the patient's medical record that he/she has a terminal condition. A *terminal condition* means a condition caused by injury, disease, or illness from which, to a reasonable degree of medical probability, the patient's condition is irreversible and incurable and (1) the patient's death is expected within a relatively short period of time, or (2) the patient is in a persistent vegetative state.

Or, I have diagnosed and certified in the patient's medical record that he/she has a chronic condition. A *chronic condition* means a chronic, debilitating disease, the cumulative effects of advanced age, or a general condition that affects all aspects of a patient's life. Further, the patient has directly or through an agent or guardian as indicated below, expressed verbally or in writing to me that he/she does not want to be resuscitated should a life threatening event occur; and I am in agreement with his/her wishes.

I further certify the patient is *INCAPABLE of making and communicating an informed decision* about providing, withholding or withdrawing resuscitation efforts because he/she is unable to understand the nature, extent, or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision, or is incapable of expressing such decision orally or in writing.

I hereby direct any and all qualified Emergency Medical Services personnel, commencing on the order date noted above, to withhold cardiopulmonary resuscitation (chest compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide to the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain, consistent with Maine EMS protocol.

Signature of Attending Physician

Date Order Signed _____

Printed Name

Phone # (emergency)

SIGNATURE OF DESIGNATED AGENT OR OTHER AUTHORIZED DECISION MAKER

I, the undersigned, hereby certify that I am authorized to provide consent on the patient's behalf by virtue of my relationship to the patient as _____ (in order of priority: designated agent, guardian, spouse, adult child, parent, representative of group opinion, adult brother or sister, other relative in descending order of blood relationship). In that capacity, I hereby direct that in the event of the patient's cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation *not* be initiated. I understand that I may revoke these directions at any time by physical cancellation or destruction of this form, and/or the DNR wallet card and/or accompanying bracelet (whichever are being used to communicate this order); or by verbally expressing a desire to have the patient be resuscitated to Emergency Medical Services (EMS) personnel. I also understand that if EMS personnel have any doubts about the applicability or validity of this order, they will begin resuscitation.

Signature of Authorized Decision Maker

Full Name (please print)