Maryland Emergency Medical Services (EMS) Do Not Resuscitate (DNR) and Medical Care Order

REVISED AUGUST 2010

This form is a physician's or nurse practitioner's order under which EMS personnel will not attempt resuscitation when the patient named below is in cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous breathing). This form also instructs EMS personnel on interventions before arrest. EMS personnel who see this order or a copy of it or physical evidence of it (the attached bracelet or Medic Alert bracelet or necklace with DNR emblem) are to provide care in accordance with this order and applicable Maryland Medical Protocols for EMS Providers. Unless a later physician's or nurse practitioner's order relating to resuscitation has been issued, or unless the health care provider reasonably believes the EMS/DNR order has been revoked, **every health care provider and facility is directed by law to follow the EMS/DNR order by not resuscitating a patient who lacks a pulse or spontaneous respirations.**

Patient Identifying Information

Name: ______________________________

Date of Birth: ______________________________

Physician's or Nurse Practitioner's Order (Mark One)

I, the undersigned licensed physician or nurse practitioner, hereby order that emergency medical services personnel provide care as specified below.

☐ **Option A: (DNI) Comprehensive Efforts to Prevent Cardiac/Respiratory Arrest Without Intubation**
DNR if Arrest Occurs-No CPR

Prior to arrest, comfort care and all interventions allowed under The Maryland Medical Protocols for EMS Providers, **except intubation - Do Not Intubate (DNI).** No CPR if arrest occurs.

☐ **Option B: Supportive Care Prior to Cardiac/Respiratory Arrest**
DNR if Arrest Occurs-No CPR

Prior to arrest, opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning for comfort and other comfort measures, splinting, pain medication by orders through on-line medical direction, and transport as appropriate. No CPR if arrest occurs.

Physician's or Nurse Practitioner's Certification (Mark One)

I hereby certify that this order is entered as a result of discussion with, and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in advance directive; or
_____ the patient's surrogate (including a legal guardian, if one has been appointed); or
_____ if the patient is a minor, the patient's parent or legal guardian.

If none of these are indicated, I certify that I entered this order on the basis of:

_____ instructions in the patient's advance directive; or
_____ the certification of two physicians that CPR would be medically ineffective.

Physician's or Nurse Practitioner's Signature and Identifying Information

Name: ______________________________
Signature: ______________________________
Date: ______________________________
Maryland License Number: ______________________________
Physician or Nurse Practitioner Phone Number: ______________________________

If bracelet is to be used used, complete all information, including physician's or nurse practitioner's signature, on each bracelet and separate at perforation.

Use of an EMS/DNR bracelet is OPTIONAL at the discretion of the patient or authorized decision maker.

Type or print legibly, have physician or nurse practitioner sign, tear off strip, fold, trim and insert in bracelet.

fold here

A (DNI) ☐ COMPREHENSIVE EFFORTS TO PREVENT CARDIAC/RESPIRATORY ARREST, DNR IF ARREST OCCURS - NO CPR
B ☐ SUPPORTIVE CARE PRIOR TO CARDIAC/RESPIRATORY ARREST, DNR IF ARREST OCCURS - NO CPR

Pt. Name: __________ Pt. DOB: ___/___/___
MD/N.P. Name: __________ Order Date: ___/___/___
MD/N.P. Sign: __________ MD/N.P. Ph.# (___)________

DO NOT CUT THROUGH INSERT- KEEP/RETURN WITH PATIENT

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Type or print legibly, have physician or nurse practitioner sign, tear off strip, fold, trim and insert in bracelet.

fold here

A (DNI) ☐ COMPREHENSIVE EFFORTS TO PREVENT CARDIAC/RESPIRATORY ARREST, DNR IF ARREST OCCURS - NO CPR
B ☐ SUPPORTIVE CARE PRIOR TO CARDIAC/RESPIRATORY ARREST, DNR IF ARREST OCCURS - NO CPR

Pt. Name: __________ Pt. DOB: ___/___/___
MD/N.P. Name: __________ Order Date: ___/___/___
MD/N.P. Sign: __________ MD/N.P. Ph.# (___)________

DO NOT CUT THROUGH INSERT- KEEP/RETURN WITH PATIENT

Use of an EMS/DNR bracelet is OPTIONAL at the discretion of the patient or authorized decision maker.

Type or print legibly, have physician or nurse practitioner sign, tear off strip, fold, trim and insert in bracelet.

fold here

A (DNI) ☐ COMPREHENSIVE EFFORTS TO PREVENT CARDIAC/RESPIRATORY ARREST, DNR IF ARREST OCCURS - NO CPR
B ☐ SUPPORTIVE CARE PRIOR TO CARDIAC/RESPIRATORY ARREST, DNR IF ARREST OCCURS - NO CPR

Pt. Name: __________ Pt. DOB: ___/___/___
MD/N.P. Name: __________ Order Date: ___/___/___
MD/N.P. Sign: __________ MD/N.P. Ph.# (___)________

DO NOT CUT THROUGH INSERT- KEEP/RETURN WITH PATIENT

Instructions on Current Life-Sustaining Treatment Options

MUST be on the front of the active chart. MUST accompany the patient on any transfer.

Patient's Name: ______________________
Date of Birth: ______________________

This form may be used by a patient or the patient's proxy (health care agent or surrogate) to document the goals of care and instructions about life-sustaining treatment options given the patient's **current** circumstances. The patient's attending physician or another health care provider should discuss relevant options with the patient/proxy. This is not an advance directive, but this form can be used to clarify or apply an existing advance directive. A proxy's instructions must be within the proxy's legal authority. A patient/proxy who wants to use this form should initial one instruction within the parts that are now relevant and sign the form; the health care providers should also sign it.

Part A Fill in briefly, then *initial* on the line →→→	**Most Important Goal(s) of Care** (By giving these instructions, what does the patient or proxy hope to achieve?) ________

Part B Fill in	**Advance Directive and Contact Information.** If the patient has a written advance directive, check this box ☐ and *append copy.* Provide contact information for a proxy in case the patient lacks or loses capacity. ______________________ ______________________ **Name and phone number of health care agent, if one has been named, or surrogate if not.**

➡ Instructions given below should serve the main goal(s) in Part A and, if made by a proxy, must be consistent with the patient's advance directive (if any). "Other" allows for instructions that modify or change what is preprinted or to state, "No decision at this time." Do **not** initial more than one instruction per part.

Part C *Initial.* Do not "✓" or "X"	**Code Status** ________ **Yes, attempt cardiopulmonary resuscitation (CPR)** ________ **No, do not attempt CPR; allow death to occur naturally** ↘ **EMS/DNR Order to be issued if appropriate**
Part D *Initial.* Do not "✓" or "X"	**Artificial Ventilation** ________ **Artificial ventilation acceptable, even indefinitely** ________ **Artificial ventilation acceptable as therapeutic trial (time limit: ________)** ________ **No artificial ventilation** ________ **Other:**
Part E *Initial.* Do not "✓" or "X"	**Hospital Transfer Status** ________ **Transfer to hospital for any condition requiring hospital-level care** ________ **Transfer to hospital acceptable for evaluation of acute injury** ________ **Do not transfer; treat with options available outside the hospital** ________ **Other:**

Part F *Initial.* Do <u>not</u> "✓" or "X"	**Medical Workup** for significant and possibly treatable symptoms that could be evaluated through blood work, X-rays, etc. ________ **All medical tests acceptable (treatment planned for diagnosed condition)** ________ **Limited (noninvasive, low risk) medical tests only** ________ **No medical tests** ________ **Other:**
Part G *Initial.* Do <u>not</u> "✓" or "X"	**Antibiotics** ________ **Antibiotics acceptable** ________ **Antibiotics acceptable, but not by intravenous infusion** ________ **No antibiotics except if needed for comfort** ________ **Other:**
Part H *Initial.* Do <u>not</u> "✓" or "X"	**Artificially Administered Fluids and Nutrition** ________ **Artificially administered fluids and nutrition acceptable, even indefinitely** ________ **Artificially administered fluids and nutrition acceptable as therapeutic trial (time limit: __________)** ________ **Intravenous fluids acceptable; no artificially administered nutrition** ________ **No artificially administered fluids and nutrition** ________ **Other:**
Part I *Initial.* Do <u>not</u> "✓" or "X"	**Other Life-Sustaining Treatments if Applicable** **(Example: blood transfusions, kidney dialysis)** **Specify treatment:** ____________________ ________ **Acceptable, even indefinitely or repeatedly** ________ **Acceptable if recommended for an acute episode, but not indefinitely or repeatedly** ________ **Not acceptable** ________ **Other:**

Name of Patient, Health Care Agent, or Surrogate (print, and circle which one) **Signature**	 **Date:** ________________
Name of Health Care Provider Assisting with Form (print) **Signature**	**Phone:** ________________ **Date:** ________________
Physician Name (print) **Physician Signature**	**Phone:** ________________ **Date:** ________________

Review: **These instructions may be reviewed at any time – a review should occur whenever:**

- ✓ The patient is transferred from one care setting or care level to another or is discharged, or
- ✓ The patient's health status changes substantially, including loss of capacity, or
- ✓ The most important goal of care or specific treatment instructions change.

This form documents a discussion about current options.
By itself, it is not a physician's order, but should be reviewed prior to the entry of new orders.