ADVANCE DIRECTIVE / PREFERRED INTENSITY OF CARE DOCUMENTATION

SECTION I ADVANCE DIRECTIVE DOCUMENTATION

(Transcribe information from legal documents completed prior to admission. Attach copy of document)

RESUSCITATE: NO ☐ YES ☐ TUBE FEEDING: NO ☐ YES ☐

RESTRICTION ON MEDICATION: YES ☐ SPECIFY RESTRICTIONS _____
NO ☐

RESTRICTION ON TREATMENT: YES ☐ SPECIFY RESTRICTIONS _____
NO ☐

OTHER DIRECTIVES / REQUESTS (SPECIFY i.e. ORGAN DONATION): _____

Appointed Surrogate decisionmaker _____

Initial all statements below and answer, as appropriate:

If an emergency exists where there is an unanticipated condition in which immediate action is necessary to prevent serious disability or alleviate severe physical pain, you will be contacted and action taken in accordance with physician orders.

☐ I desire you to execute the attached Advance Directive.

☐ I understand that other treatment options may be presented and that I have the right to consent or refuse medical treatment(s) after being informed of risks or consequences by the physician.

☐ I understand that the attached Advance Directive can be changed and modified at any time upon notification to physician and / or facility staff.

_____ Date _____ _____ Date _____

Resident / Surrogate Facility Representative - Title

SECTION II PREFERRED INTENSITY OF CARE DOCUMENTATION

(as determined by capable resident*)

RESUSCITATE: NO ☐ YES ☐ TUBE FEEDING: NO ☐ YES ☐

RESTRICTION ON MEDICATION: YES ☐ SPECIFY RESTRICTIONS _____
NO ☐

RESTRICTION ON TREATMENT: YES ☐ SPECIFY RESTRICTIONS _____
NO ☐

OTHER REQUESTS (SPECIFY i.e. ORGAN DONATION): _____

Initial all statements below and answer, as appropriate:

If an emergency exists where there is an unanticipated condition in which immediate action is necessary to prevent serious disability or alleviate severe physical pain, you will be contacted and action taken in accordance with physician orders.

☐ I desire you to execute the "Preferred Intensity of Care Decisions" as indicated above.

☐ I understand that other treatment options may be presented and that I have the right to consent or refuse medical treatment(s) after being informed of risks or consequences by the physician.

☐ I understand that the above "Preferred Intensity of Care Decisions" can be changed and modified at any time upon notification to physician and facility staff.

_____ Date _____ _____ Date _____

Resident Facility Representative - Title

*see physician assessment on physician admission orders/progress notes

LAST NAME	FIRST NAME	INIT.	ATTENDING PHYSICIAN	ROOM NO	RESIDENT NUMBER

SECTION III PREFERRED INTENSITY OF CARE DOCUMENTATION

To be completed ***only*** when resident ***lacks capability**** for independent decisionmaking and ***no prior Advance Directive*** documents available

In the absence of the resident's written treatment instructions, the surrogate decisionmaker(s) have related the resident's stated preferences for intensity of treatment:

Describe resident preference regarding treatment (including approximate dates / circumstances surrounding the resident's expressions of PREFERRED intensity of treatment). Attach any other documentation which would provide information concerning the resident's desires.

This section must be completed with historical rationale before the decisions below are made:

_____

_____

_____

_____

_____

_____

_____

Check below as it reflects the resident's expressions of Preferred Intensity of Treatment.

RESUSCITATE: NO ☐ YES ☐ TUBE FEEDING: NO ☐ YES ☐

RESTRICTION ON MEDICATION: YES ☐ SPECIFY RESTRICTIONS _____
NO ☐

RESTRICTION ON TREATMENT: YES ☐ SPECIFY RESTRICTIONS _____
NO ☐

OTHER REQUESTS (SPECIFY i.e. ORGAN DONATION): _____

Initial all statements below and answer, as appropriate:

If an emergency exists where there is an unanticipated condition in which immediate action is necessary to prevent serious disability or alleviate severe physical pain, you will be contacted and action taken in accordance with physician orders.

- ☐ I desire you to execute the "Preferred Intensity of Care Decisions" as indicated above.
- ☐ I understand that other treatment options may be presented and that I have the right to consent or refuse medical treatment(s) after being informed of risks or consequences by the physician.
- ☐ I understand that the above "Preferred Intensity of Care Decisions" can be changed and modified at any time upon notification to physician and facility staff.

Surrogate Decisionmaker _____ Relationship to Resident _____
(Signature)

Surrogate Decisionmaker _____ Relationship to Resident _____
(Signature)

_____ Date _____
Facility Representative - Title

*see physician assessment on physician admission orders/progress notes

LAST NAME	FIRST NAME	INIT.	ATTENDING PHYSICIAN	ROOM NO	RESIDENT NUMBER