Advance Directives Summary

Although Advance Directives can take many forms, there are two main types of advance directive — the "Living Will" and the "Durable Power of Attorney for Health Care." Mercy's policy is to honor a patient's Advance Directive within the limits of the law and the guidelines of the current Ethical and Religious Directives for Catholic Health Care Services provided by the United States Conference of Catholic Bishops (USCCB). It is strongly encouraged that whenever possible, Mercy physicians have a conversation with their patients about completing an advance directive during a clinic well visit.

Highlighted below are short summaries of the most common terms.

Living Will

- Living will is one kind of an advance directive. It is a written, legal document that describes the type of treatment a patient would want if he/she should become seriously or terminally ill. A living will does not give permission to someone else to make decisions for the patient.

Durable Power of Attorney for Healthcare (DPA)

- A DPA is also another kind of advance directive. It is also a written, legal document. A DPA states who can make decisions for a patient if he/she becomes unconscious or unable to make medical decisions.

State laws do differ on advance directives. As a deliverable from a Mercy Key Initiative, a universal advance directive was created which was valid in the states for which Mercy has healthcare services which contains both the living will and DPA for Healthcare (Attachment). The Mercy form in both English and Spanish can be found on the Mercy website by entering the website link below.

http://www.mercy.net/advance-directives

The Mercy website also contains a document of frequently asked questions, as well as a glossary with additional terms often used in discussion of end of life choices.

Do Not Do Not Resuscitate (DNR) Physician Order

DNR orders are used both in hospitals and in situations where a person might require emergency care outside of the hospital.

Out of Hospital DNR

In most states, paramedics called to a home or out of hospital care setting must immediately begin resuscitation and other life saving measures unless they see a valid Out of Hospital Do Not Resuscitate Order (OOH DNR). **The OOH DNR order must be completed on the form specified by the state where the emergency occurs and signed by the physician.** Each state has their own DNR forms, and most states do not recognize DNR orders from other states. The forms for MO, KS, OKL and ARK are attached.

POLST/TPOPP Forms

Many states are starting to use a form that is similar to a DNR order, but differs in a few important ways. The form is most often called Physician Orders for Life-Sustaining Treatment (POLST), though some states use other names, such as in Missouri and Kansas the name is Transportable Physician Orders for Patient Preferences (TPOPP). This form may be used in addition to—or instead of—a DNR order. The TPOPP form is provided as an attachment.

Like a DNR order, this form tells emergency medical personnel and other medical providers whether or not to administer cardiopulmonary resuscitation (CPR) in case of emergency. The form is often prepared to ensure that different health care facilities and service providers (including EMS personnel) understand a patient's wishes. In most states, it is printed on brightly colored paper so it will easily stand out in a patient's medical records. **To be valid, the form must be signed by a doctor or other approved health care professional.**

Taken together, a Living Will and Durable Power of Attorney for Health Care provide more information than a DNR form, including details about your health care agent, more complete health care wishes, and your preference for organ donation.

If you have a POLST or TPOPP form, you do not need a DNR order, but you should still complete additional health care directive. Unlike a DNR order, a POLSTor TPOPP form also includes directions about life-sustaining measure such as intubation, antibiotic use and feeding tubes. The POLST or TPOPP form helps to ensure that medical providers will understand your wishes at a glance, but it is ***not*** a substitute for a thorough and properly prepared health care directive.

The following website contains additional information for review on both the POLST and TPOPP documents.

www.POLST.org.

ADVANCE DIRECTIVE FORMS and MY RIGHTS TO GUIDE MY HEALTH CARE

NAME: _____ **DATE OF BIRTH:** _____

SSN: XXX - XX - _____ **(last 4 digits only)**

I am at least 18 years old, and of sound mind. I have received information regarding my rights to make advance directives and I understand the following statements.

- Federal and state laws say I can write down my choices now for future health care decisions. If someday I am sick or injured and cannot make health care decisions for myself, written advance directives can help guide my physicians and others in making treatment plans or in the use of life-sustaining (life-prolonging) procedures.
- **I can use Part A** of this form to name another person to talk to my physicians and make health care decisions for me if I cannot, (this is one type of advance directive and is often called a durable power of attorney for health care or health care proxy);

AND/OR

- **I can use Part B** of this form to directly tell my physicians about my choices if I become unable to tell them myself in the future (this is another type of advance directive and is often called a health care directive, declaration or living will).
- No one can require me to sign an advance directive. I have the right to choose to not do an advance directive at all.
- This information and these forms have been provided for my convenience. I may use another form of an advance directive or I may use this form with changes or additions. My health care providers can help me with questions and provide more information. My advance directive will be made a part of my medical record if I give a copy of it to my providers. Some states also have an advance directive registry where I may file my documents so others can find them when needed. A copy of an advance directive is valid. It is helpful if I also let others in my life know my choices and have a copy of my advance directive(s).
- Advance directives are not to be used for euthanasia, assisted suicide or any deliberate or affirmative act or omission to shorten or end life in a manner not permitted by law.
- For the purposes of these documents, medical treatment and procedures are referred to as life-sustaining (life-prolonging) if their use would only prolong the dying process or maintain the patient in a persistently unconscious state.
- I may choose to forgo life-sustaining (life-prolonging) treatments and procedures which are burdensome or disproportionate without reasonable hope of recovery.
- Comfort care and pain relief always will be given to me.
- While I have a right to consent to or to refuse treatment, I may not likely be offered treatment which is considered ineffective or futile by my health care providers.
- While I am pregnant, my advance directive to forgo life-sustaining treatment may not be followed under state law, except under special circumstances.
- I may revoke an advance directive any time; signing a new advance directive cancels previous ones.
- For more information on The Patient Self-Determination Act of 1990 or state laws on advance directives, I may contact the state attorney general, consult my attorney or health care provider or visit **mercy.net**.
- My health care provider is to let me know if my advance directive choices and instructions cannot or will not be followed, and is to transfer my care to another provider or facility in that event.

Mercy

PART A. DURABLE POWER OF ATTORNEY FOR HEALTH CARE (Health Care Proxy) To Appoint Another Person ("Agent/Proxy") To Make Health Care Decisions When I Can No Longer Make Them

NAME: _____ **DATE OF BIRTH:** _____

SSN: XXX - XX - _____ **(last 4 digits only)**

This is a Durable Power of Attorney for Health Care and the authority of my Agent/Proxy, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

1. I want to name another person to make decisions about my health care if I am not able to decide for myself any more. The person I name as my Agent/Proxy may then have access to my health information and medical records and will be my personal representative with the power and authority to: choose my health care providers and place of care (including my home); make decisions about my treatment; and consent to, refuse or withdraw treatment, including life-sustaining (life-prolonging) procedures.

2. This document becomes effective when I am unable to make and communicate decisions as certified by two of my physicians or as otherwise permitted by law. I may initial here to let just one physician certify (in Missouri):

_____ One physician may certify my inability to make health care decisions.
Initials

3. AGENT/PROXY:

A. I appoint the following person as my true and lawful Agent/Proxy, (also called attorney-in-fact):

Name: _____

Address: _____

_____

Phone(s): 1st _____ 2nd _____

B. Alternate Agent/Proxy (optional). If the person above is not willing or available to make health care decisions for me, or if we are divorced or legally separated in the future, then I appoint the following person in the order below as my alternate Agent/Proxy and to have the powers described herein.

First Alternate Agent/Proxy	**Second Alternate Agent/Proxy**
Name:_____	Name:_____
Address:_____	Address:_____
Phone(s): 1st _____	Phone(s): 1st_____
Phone(s): 2nd _____	Phone(s): 2nd_____

4. ARTIFICIALLY-SUPPLIED NUTRITION AND HYDRATION: My health care Agent/Proxy is authorized to make whatever medical treatment decisions I could make if I were able, AND further:
(Initial only one below.)

_____ **I DO AUTHORIZE** my Agent/Proxy to direct a health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water) as permitted by law;*

OR

_____ **I DO NOT AUTHORIZE** my Agent/Proxy to direct a health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water) as permitted by law;*

** (In a Mercy health care facility, nutrition and hydration may be withheld or withdrawn if I have an irreversible condition which is end-stage or terminal AND if means of preserving my life have likely risks and burdens which outweigh the expected benefits or are disproportionate without a reasonable hope of benefit.)*

5. **FURTHER POWERS OF AGENT/PROXY:** Unless I have marked out a power below and initialed the mark, I also grant the following powers to my Agent/Proxy:
   - May determine what happens to my body after my death;
   - May consent to an autopsy.

My Agent/Proxy will have no personal financial liability for my health care and will not be paid for his or her service under this Durable Power of Attorney for Health Care; however my Agent/Proxy may receive reimbursement for reasonable out-of-pocket expenses.

SIGNATURE FOR PART A

IN WITNESS WHEREOF, I signed this Durable Power of Attorney for Health Care (Health Care Proxy) on this _____ day of _____, in the year _____.

_____ _____

Signature **Address**

_____

Printed Name

(Notary required in Missouri on Durable Power of Attorney For Health Care – Part A – Other States may use two witnesses – see below.)
(Texas residents must sign a disclosure statement before signing a Medical Power of Attorney. See http://www.caringinfo.org/files/public/ad/Texas.pdf)

WITNESSES FOR PART A

WITNESSES: The above Durable Power of Attorney for Health Care (Part A) was voluntarily signed in my presence on this _____ day of _____, in the year _____. I am at least 18 years old and am not related to, not financially responsible for the health care of, and am not an heir to, the person who signed the document.

Signature:_____ Signature: _____

Print Name: _____ Print Name:_____

Address:_____ Address: _____

_____ _____

— OR —

NOTARY ACKNOWLEDGEMENT – FOR PART A - MISSOURI

State of _____)
) ss
County of _____)

On this _____ day of _____, in the year _____, before me, the undersigned notary public, personally appeared _____ known to me to be the person whose name is subscribed to the foregoing Durable Power of Attorney for Health Care and acknowledged that he/she executed the same for the purposes therein contained. IN WITNESS WHEREOF, I hereunto set my hand and official seal.

_____

Notary Public Signature
(Notary Public Seal)

PART B: HEALTH CARE DECLARATION/LIVING WILL
My Choices About Life-Sustaining Treatment and Other Care

NAME: _____ **DATE OF BIRTH:** _____

SSN: XXX - XX - _____ **(last 4 digits only)**

If I am not able to make and communicate health care decisions, then my physicians are to follow my written choices for the use of life-sustaining (life-prolonging) treatments if I have an irreversible condition which is end-stage or terminal or where thought and awareness of self and environment are absent (persistently unconscious). This is in exercise of my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions. My physicians and Agent/ Proxy are to reasonably try to follow my choices and instructions as shown by my initials below:

1. _____ I direct and authorize my health care provider to withhold or withdraw ALL life sustaining (life-prolonging) treatment and procedures as permitted by law.*

OR

By my initials below, I make the following specific choices to show what treatments I DO NOT WANT to receive:

_____ surgery or other invasive procedure;

_____ antibiotics;

_____ mechanical ventilator (respirator);

_____ radiation therapy;

_____ heart-lung resuscitation (CPR);

_____ dialysis;

_____ chemotherapy;

_____ other "life-prolonging" medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury.

However, if my physician believes that any life-sustaining (life-prolonging) procedure may lead to recovery significant to me, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I may be given treatment to relieve pain or to provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

2. ARTIFICIAL NUTRITION AND HYDRATION – I further make the following choice as indicated by my initials below:
(Initial only one below.)

_____ **I DO AUTHORIZE** my health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water) as permitted by law;*

OR

_____ **I DO NOT AUTHORIZE** my health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water) as permitted by law;*

** (In a Mercy health care facility, nutrition and hydration may be withheld or withdrawn if I have an irreversible condition which is end-stage or terminal AND if means of preserving my life have likely risks and burdens which outweigh the expected benefits or are disproportionate without a reasonable hope of benefit.)*

3. **ADDITIONAL CHOICES AND INSTRUCTIONS –** Other important choices and instructions for my health care which are not described somewhere else in this document may be described below. (For example, these might be social, cultural, or faith-based choices for care, or choices about treatments such as feeding tubes, blood transfusions, or pain medications. Statements about my significant values or goals for recovery or care may be included below.)

(If no additional choices or instructions, please mark through this box with an X and initial.)

SIGNATURE FOR PART B

IN WITNESS WHEREOF, I signed this Health Care Declaration/Living Will on this _____ day of _____, in the year _____.

_____ _____

Signature **Address**

_____

Printed Name

WITNESSES FOR PART B

WITNESSES: The above Health Care Declaration/Living Will (Part B) was voluntarily signed in my presence on this _____ day of _____, in the year _____. I am at least 18 years old and am not related to, not financially responsible for the health care of, and am not an heir to, the person who signed the document.

Signature:_____ Signature: _____

Print Name: _____ Print Name:_____

Address:_____ Address: _____

_____ _____

- For Educational Purposes Only -

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP)

This Physician Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. Photocopy or fax copy of this form is valid.

Last Name:	First Name:	Middle Initial:
Date of Birth:	Last 4 SSN:	Gender: **M** **F**

A. CHECK ONE

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. If patient is not in cardiopulmonary arrest, follow orders in B and C.

☐ **Attempt Resuscitation/CPR** *(Selecting CPR in Section A requires selecting Full Treatment in Section B)*
☐ **Do Not Attempt Resuscitation** *(DNAR/no CPR/Allow Natural Death)*

B. CHECK ONE

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Comfort Measures Only.**
Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.
TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY.

☐ **Limited Additional Interventions.**
In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital only if treatment needs cannot be met in current location.
TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.

☐ **Full Treatment.**
In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.
TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS.

Additional Orders: _____

C. CHECK ONE

MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.

☐ No medically administered nutrition, including feeding tubes.
☐ Medically administered nutrition, including feeding tubes, for trial period: _____
☐ Long term medically administered nutrition, including feeding tubes

Additional Orders: _____

D. CHECK ALL THAT APPLY

INFORMATION AND SIGNATURES

Discussed with:
☐ Patient/Resident ☐ Agent/DPOA healthcare ☐ Parent of minor ☐ Legal guardian
☐ Health care surrogate ☐ Other *(specify)*: _____

Signature of patient or recognized decision maker
By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form.

Print name:	Signature *(required)*:	Relationship *(write "self" if patient)*:
Address:		Phone:

Signature of physician
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print physician name:		Physician phone:
Physician signature *(required)*:		Date:

Practitioners: Go to www.practicalbioethics.org for TPOPP resources

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

September 2012

- For Educational Purposes Only -

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Last 4 SSN:	Gender: M F

E. ADVANCE DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

Healthcare Directive or other Advance Directive ☐ No ☐ Yes

Durable Power of Attorney for Healthcare Decisions document* ☐ No ☐ Yes

*Name: _____ Phone: _____

Health Care Providers Assisting with Form Preparation

Name:	Title:	Phone:
Name:	Title:	Phone:

Completing TPOPP

- Completing a TPOPP form is always voluntary. TPOPP is a useful tool for the understanding of and implementation of physicians' orders that are reflective of the current medical condition and preferences of a patient. The orders are to be respected by all receiving providers in compliance with institutional policy. On admission to the hospital setting, a physician who will issue appropriate orders for that inpatient setting will assess the patient.
- TPOPP is a physician order set and as such does not replace Advance Directives but should serve to clarify them.
- TPOPP must be completed by a health care provider based on patient preferences and medical indications. Upon completion it must be signed by a physician and patient *(or representative)* to be recognized as valid.
- Use of original form is strongly encouraged. Photocopies and Faxes of signed TPOPP forms are valid. A copy should be retained in patient's medical record.

Using TPOPP

- Any incomplete section of TPOPP implies full treatment for that section.

SECTION A:

– If found pulseless and not breathing, no defibrillator *(including automated external defibrillators)* or chest compressions should be used on a person who has chosen "Do Not Attempt Resuscitation."

SECTION B:

– When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort *(e.g., treatment of a hip fracture)*.

– Non-invasive positive airway pressure includes continuous positive airway pressure *(CPAP)*, bi-level positive airway pressure *(BiPAP)*, and bag valve mask *(BVM)* assisted respirations.

– If person desires IV fluids, indicate "Limited Interventions" or "Full Treatment."

Reviewing TPOPP

TPOPP form should be reviewed when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding TPOPP

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a TPOPP by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.

More Information: TPOPP@practicalbioethics.org

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

ARKANSAS STATE BOARD OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA SYTEMS

RULES AND REGULATIONS
FOR
EMERGENCY MEDICAL SERVICES
DO NOT RESUSCITATE

Promulgated Under the Authority of (Act 1101 of 1993)

Effective Date April 1995
This Revision Effective July 2005
By the Arkansas State Board of Health

Division of Health
Little Rock, Arkansas
Paul K. Halverson, DrPH, Director

RULES AND REGULATIONS PERTAINING

TO

EMERGENCY MEDICAL SERVICES

DO NOT RESUSCITATE

TABLE OF CONTENTS

TO
EMERGENCY MEDICAL SERVICES
DO NOT RESUSCITATE

SECTION I.

AUTHORITY

The following Rules and Regulations Pertaining to Emergency Medical Services are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by Act 1101 of 1993 (Ark. Code Ann. § 20-13-901 *et seq*.) and the laws of the State of Arkansas including without limitation, Act 96 of 1913 (Ark. Code Ann. § 20-7-109)

DEFINITIONS

1.1 - Definitions:

The following words and terms, when used in these regulations, shall have the following meaning unless the context clearly indicates otherwise:

“Ambulance Service” means those services authorized and licensed by the Department to provide care and transportation of patients upon the streets and highways of Arkansas.

"Attending Physician" means the physician who has the primary responsibility for the treatment and care of the patient.

"Board" means the State Board of Health.

"Cardiac Arrest" means the cessation of a functional heartbeat.

"Cardiopulmonary Resuscitation" means medical procedures including: cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures.

"Department" means the Division of Health.

"Director" means the State Health Division Director.

"Emergency Medical Services (EMS)" means the transportation and medical care provided the ill or injured prior to arrival at a medical facility by a certified emergency medical technician (EMT) or other healthcare provider and continuation of the initial emergency care within a medical facility subject to the approval of the medical staff and governing board of that facility.

"Emergency Medical Services Do Not Resuscitate Order ("EMS/DNR Order") means a written

physician's order in a form consistent with section 2.1 which authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from a particular patient in the event of cardiac or respiratory arrest.

"Emergency Medical Services Personnel" ("EMS Personnel") means paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency personnel acting within the ordinary course of their professions.

“Emergency Medical Services Do Not Resuscitate (“EMS/DNR”) Order Implementation Protocol” means a set of instructions developed by the emergency medical service provider to respond to emergency medical needs and approved by the Medical Director of the Emergency Medical Services provider.

“EMS/DNR Order Form” means a document as approved by the Board, or one created or used by a physician that is consistent with these regulations.

"Health Care Proxy" is a person eighteen (18) years old or older appointed by the patient as attorney-in-fact to make health care decisions including the withholding or withdrawal of life-sustaining treatment If a qualified patient, In the opinion of the attending physician, Is permanently unconscious, incompetent, of otherwise mentally or physically incapable of communication, as specified in AR Statutes 20-17-201(10).

“No Code or DNR” means an instruction or order to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures) from the patient in the event of the patient’s cardiac or respiratory arrest.

"Respiratory Arrest" means cessation of breathing.

SECTION II

REQUIREMENTS AND PROVISIONS

General Provisions

2.1 - The Emergency Medical Services Do Not Resuscitate Order Form:

The EMS/DNR Order Form shall be a document as approved by the Board, or one created or used by a physician that is consistent with these regulations. The following requirements and provisions shall apply to any EMS/DNR Order Form.

A. Content of the Form - A valid EMS/DNR Order Form shall include the words “DNR” or “No Code,” or similar language, and the physician’s signature and the date.

B. Copies of the EMS/DNR Order Form may be given to other providers or persons for information.

C. Revocation of an EMS/DNR Order - An EMS/DNR Order may be revoked at any time or in any manner by the named patient or patient’s attending physician.

D. Distribution of EMS/DNR Order Forms - EMS/DNR Forms approved by the Board, with instructions, shall be available to physicians through local Health Department offices, local hospitals, ambulance services, and to private physicians, on request. Other distribution points may be approved by the Director to meet identified needs.

SECTION III

IMPLEMENTATION PROCEDURES

3.1 - Issuance of an EMS/DNR Order:

An EMS Do Not Resuscitate Order may only be issued by the patient's attending physician.

3.2 - EMS Do Not Resuscitate Implementation Procedures:

Emergency Medical Services personnel shall comply with the EMS/DNR Order implementation protocols when responding to a patient who is in cardiac or respiratory arrest and who is known to have an EMS/DNR Order in effect as approved by the Department.

3.3 - General Considerations

The following general principles shall apply to implementation of EMS Do Not Resuscitate Orders:

If there is misunderstanding with family members or others present at the scene or if there are other concerns about following the EMS/DNR Orders, contact the attending physician or EMS medical control for guidance. If there is any question about the validity of an EMS/DNR Order, resuscitate.

SECTION IV.

REPEAL

4.1 All Regulations and parts of Regulations in conflict herewith are hereby repealed.

SECTION V.

CERTIFICATION

This will certify that the foregoing Rules and Regulations for Emergency Medical Services Do Not Resuscitate were adopted by the Arkansas Board of Health at a regular session of said Board held in Little Rock, Arkansas on the Twenty-eighth day of July, 2005.

_____

Paul K. Halverson, DrPH
Director, Division of Health

The forgoing Rules and Regulations, copy having been filed in my office, are hereby approved on this _____day of _____, 2005.

_____

Mike Huckabee
Governor

NO CPR
DO NOT
RESUSCITATE
DNR

STATE OF ARKANSAS
EMERGENCY MEDICAL SERVICES
DO NOT RESUSCITATE ORDER

Patient's Full Name: _____

_____ _____

Signature of Patient or Health Care Proxy or Legal Guardian Date

ATTENDING PHYSICIAN'S ORDER

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

I hereby direct any and all qualified Emergency Medical Services personnel, commencing on the effective date noted below, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, 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.

_____ _____

Signature of Attending Physician Physician’s Telephone number (emergency #)

_____ _____

Physician's Printed/Typed Name Date Order Written