DO NOT ATTEMPT RESUSCITATION (DNR)

This Physician Order is based on the medical condition and/or wishes of the patient and/or of the person(s) signing below.
Complete ALL sections

Section A *Check one*	**CARDIOPULMONARY RESUSCITATION (CPR) Patient has no pulse AND is not breathing** ☐ **Attempt FULL Resuscitation – ventilation, mechanical CPR – compressions, defibrillation** ☐ **DO NOT ATTEMPT RESUSCITATION (DNR)**
Section B Check one if applies	**MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing** ☐ **Comfort Measures (Allow Natural Death): treatment goal: maximize comfort through symptom management. Relieve pain, suffering through use of medications, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction PRN for comfort** ☐ **Limited Additional Interventions: treatment goal: In addition to care described above, use medical treatment for stabilization, IV fluids, vasopressors, and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. *No intubation*.**
Section C Check one	**Antibiotics:** ☐ **Use antibiotics for infection only if comfort cannot be achieved fully through other means.** ☐ **Use antibiotics consistent with treatment goals**
Section D Check one	**Artificially Administered Nutrition:** ☐ **No artificial nutrition** ☐ **Defined trail period of artificial nutrition by tube** ☐ **Long-term artificial nutrition**

Section E *Check all that apply*	**Discussed with:** ☐ Patient ☐ Healthcare Representative ☐ Court-appointed guardian ☐ Parent of a minor ☐ Other: ________________________	**The Basis for This Order is as follows:** ☐ **Patient's preferences** ☐ **Patient's best interest** (patient lacks capacity or preferences are unknown) ☐ Medical indications ☐ (Other) ____________________________(Specify)

Note:____
____

Requires Signature of Patient, or Parent if patient is a Minor, Guardian or Health Care Representative below.
See policy IPC.ETH.006 for legal Healthcare Consent Hierarchy

________________________________ Signature and Date AND TIME	____________________________ Name (print)	________________________ Relationship (write "self" if patient)
________________________________ Witness Signature and Date AND TIME	____________________________ Witness Name (print)	

Telephone order if needed:

Nurse Signature: _________________________________ Date AND Time: _________________________

Nurse Signature: _________________________________ Date AND Time:__________________________

PHYSICIAN SIGNATURE: Date AND Time:

LIST 176, 178.Physician Orders for Scope of Treatment – POS

Patient Label

POS