Utah Department of Health
Bureau of Health Facility Licensing, Certification and Resident Assessment

Physician Order for Life Sustaining Treatment
Utah Life with Dignity Order
Version 2 – 9/09

State of Utah Rule R432-31
(http://health.utah.gov/hflcra/forms.php)

This is a physician order sheet based on patient wishes and medical indications for life-sustaining treatment. Place this order in a prominently visible part of the patient’s record. Both the patient and the physician must sign this order (two physicians must sign if the patient is a minor child). When the patient’s condition makes this order applicable, first follow this order, and then, if necessary, contact the signing physician.

<table>
<thead>
<tr>
<th>Physician’s Name:</th>
<th>Last Name of Patient:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Physician’s Name:</th>
<th>First Name/Middle Initial:</th>
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<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Effective Date of this Order:</th>
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(If nothing in a section is checked, caregivers should provide the fullest treatment described in that section unless that treatment directly conflicts with a treatment checked in another section)

### Section A

**Check one**

- Attempt to resuscitate
- Do not attempt or continue any resuscitation (DNR)

Other instructions or clarification:

### Section B

**Check one**

- Comfort measures only: Oral and body hygiene; reasonable efforts to offer food and fluids orally; medication, oxygen, positioning, warmth, and other measures to relieve pain and suffering. Provide privacy and respect for the dignity and humanity of the patient. **Transfer to hospital only if comfort measures can no longer be effectively managed at current setting.**

- Limited additional interventions: Includes care above. May also include suction, treatment of airway obstruction, bag-valve-mask ventilation, monitoring of cardiac rhythm, medications, IV fluids. **Transfer to hospital if indicated, but no endotracheal intubation or long-term life support measures.**

Other instructions or clarification:

- Full treatment: Includes all care above plus endotracheal intubation, defibrillation/cardioversion, and any other life sustaining care required.

If necessary, transfer to (hospital name):

Other Instructions or clarification:

### Section C

**Check all that apply**

- Antibiotics: (Comfort measures are always provided)

- No antibiotics
- Antibiotics may be administered

Other Instructions or clarification:
Artificially administered fluid and nutrition: (Comfort measures are always provided)

**Feeding Tube:**
- [ ] No feeding tube
- [ ] Defined trial period of feeding tube
- [ ] Long-term feeding tube

**IV Fluids:**
- [ ] No IV fluids
- [ ] Defined trial period of IV fluids
- [ ] IV Fluids

Other Instructions or Clarification:

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**Section E**

Check all that apply

**Discussed with:**
- [ ] Patient / Parent(s) of Minor Child
- [ ] Surrogate (source of legal authority, name, and phone number):
- [ ] Other (name and phone number): ____________________________________________

Patient preferences to guide physician in ordering life-sustaining treatment

**Section F**

I have given significant thought to life-sustaining treatment. Please see the following for more information about my preferences:

Advance Directive: ____ no ____ yes

Other: ____________________________________________

I have expressed my preferences to my physician or health care provider(s) and agree with the treatment order on this document. Please review these orders if there is a substantial permanent change in my health status, such as:

- Close to death
- Advance progressive illness
- Improved condition
- Permanently unconscious
- Extraordinary suffering
- Surgical procedures

**Brief summary of medical condition and brief explanation of treatment choice:**

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Signature of person preparing form (if not patient's physician)  Print name and phone number  Date prepared:

Signature of physician or other licensed practitioner  Print name and license number  Date signed:

Signature of second physician or other licensed practitioner (required for minor patients only)  Print name and license number  Date signed:

Patient, Parent, or Surrogate signature  Print name and phone number  Date signed:

Patient, Parent, or Surrogate signature  Print name and phone number  Date signed:

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**Review and Change to Life with Dignity Order**

Review this form whenever any of the following happen:

1. The patient is transferred from one care setting to another;
2. The patient’s health status changes substantially and permanently; or
3. The patient's treatment preferences change.

If the patient or the patient’s surrogate changes the treatment preferences in this order, complete a new form and place it in the patient’s medical record. This form is valid for both adult and pediatric patients.

A COPY OF THIS FORM MUST ACCOMPANY THE PATIENT WHEN TRANSFERRED OR DISCHARGED (INCLUDING TRANSFERS TO HOSPITAL EMERGENCY DEPARTMENTS)