Resuscitation Plan

Resident Name_____ **Date:**_____

Statement of Ethics

We recognize that individuals have the right to decide what quality of life means to them. We recognize that dying is a natural process, and that individuals and/or the designated legal representatives have the right to make the best decisions for his/her life and health. Therefore, we honor decisions made by the individual in partnership with the healthcare team. All measures to assure the patient's comfort and dignity will be maintained.

☐ Maximum Therapeutic Effort

Perform Cardiopulmonary Resuscitation (CPR) and transport to the hospital for further treatment. ***(No physician order is necessary).***

☐ DNR I (Limited Intervention Measures)

No Cardiopulmonary Resuscitation (CPR). Patient may be transferred to the hospital as deemed medically necessary. ***(Physician order required).***

☐ DNR II (Comfort Measures only)

No Cardiopulmonary Resuscitation (CPR). Care and comfort measures will be administered within the facility, but the patient will not be transferred to the hospital for treatment. ***(Physician order required).***

_____

Resident or Responsible Party Date

_____

Legal Guardian or Durable Power of Attorney for Healthcare Date

_____

Facility Representative Date

Those with a Maximum Therapeutic Effort plan will be reviewed periodically.

Review Date	Staff Signature	Resident or Resp. Party Signature	Comments