

LIMITED TREATMENT PLAN ORDER SHEET

The discussion and rationale for orders below shall be documented in the progress notes of the hospital chart.

| <u>Date</u> | <u>Time</u> | |
|-------------|-------------|--|
| _____ | _____ | <input type="checkbox"/> Do Not Cardiovert |
| _____ | _____ | <input type="checkbox"/> Do Not Defibrillate |
| _____ | _____ | <input type="checkbox"/> Do Not Intubate |
| _____ | _____ | <input type="checkbox"/> Do Not Resuscitate |
| _____ | _____ | <input type="checkbox"/> Do Not Transfer to ICU |
| _____ | _____ | <input type="checkbox"/> No vasopressor/inotropic agents |
| _____ | _____ | <input type="checkbox"/> No mechanical ventilation |
| _____ | _____ | <input type="checkbox"/> No antiarrhythmics |
| _____ | _____ | <input type="checkbox"/> No hyperalimentation |
| _____ | _____ | <input type="checkbox"/> No tube feedings |
| _____ | _____ | <input type="checkbox"/> No dialysis |
| _____ | _____ | <input type="checkbox"/> No blood/blood products |
| _____ | _____ | <input type="checkbox"/> No electrolyte or acid/base corrective measures |
| _____ | _____ | <input type="checkbox"/> No blood tests or x-rays |
| _____ | _____ | <input type="checkbox"/> No antibiotics |
| _____ | _____ | <input type="checkbox"/> All of the above |
| _____ | _____ | <input type="checkbox"/> Other (please specify) _____ |

Physician Signature _____

Printed Name _____

Cancel above Limited Treatment Plan Orders. Please put slash across order sheet with date and time.

Physician Signature _____ Date _____

Printed Name _____