Nebraska Emergency Treatment DECLARATION

Name: _____ DOB: _____ DATE: _____

This Treatment Declaration is my acknowledgment and authorization to accept, limit or refuse medical treatment if I have a life-limiting condition and I am unable to make and/or communicate my own decisions. I have initialed the medical directives I have chosen for treatment in each section below. I have discussed my choices with my doctor, and I understand that my directive will be followed whether I have a life-threatening injury or a medical emergency. I ask everyone who may make medical decisions on my behalf to follow these directives as closely as my condition allows.

SECTION A: Scope of Medical Treatment Desired

____ **1.** I want ALL medically indicated interventions, including **intensive life-sustaining** measures required to attempt to treat the emergency condition.

____ **2.** I want LIMITED medically indicated interventions. Use **general medical** interventions including, but not limited to: medications, fluids, blood products and non-invasive ventilation. I DO NOT WANT TO BE INTUBATED. I want to avoid surgery and avoid ICU.

____ **3.** I DO NOT want to treat the emergent condition. I want to be allowed to die naturally, using medical treatment for **comfort purposes only**. I will allow medication and oxygen for my medical symptoms. I DO NOT want antibiotics, blood products or fluids to prolong my life. I agree to Hospice if indicated for my care.

SECTION B: Stopping Treatment

Life-sustaining treatment is generally continued as long as the possibility exists of reversing the medical condition. But some patients may choose to stop receiving these treatments before that time if treatment is failing, or if it is likely that their medical condition after treatment would be unacceptable to them.

If, after medical treatment has been initiated as referenced in section A, I am not able to make or communicate medical decisions:

____ **1.** I wish to **continue on** life support as long as it is medically indicated. I understand this may require a transfer to a long-term care facility on a breathing machine.

____ **2.** I instruct my physicians and surrogates to **stop** treatment for any of the reasons I have initialed below. I have ~~DRAWN A LINE THROUGH THE OTHER OPTIONS:~~

____ a. I worsen or do not substantially improve ☐ within a few days; **or** ☐ before long-term life support is needed (10-14 days).

____ b. It is likely I will have lasting, serious brain damage.

____ c. It is unlikely I will be able to live at home again.

____ d. If my medical decision maker(s) believe the burdens of treatment are too high for the expected benefit, or my life after treatment would be unacceptable to me based on what I've told them or what they know about me.

SECTION C: Resuscitation status for Cardiopulmonary Arrest

____ **1. ATTEMPT** CARDIOPULMONARY RESUSCITATION (CPR) if medically indicated. **(MUST SELECT #1 IN SECTION A)**

____ **2. DO NOT** ATTEMPT CARDIOPULMONARY RESUSCITATION (DNR)

SECTION D: Long Term Medically Administered Nutrition and Hydration

Anyone who can safely take food or water by mouth is always offered food or water. Patients who are receiving active medical treatment are provided appropriate nutrition and/or hydration.

If, after medical treatment, I am not able to make medical decisions for myself AND I am not able to take food or water by mouth:

____ **1.** I WANT nutrition provided through a tube surgically placed in my stomach.

____ **2.** I DO NOT WANT a tube surgically placed in my stomach, and I refuse medically administered nutrition and hydration.

Your Signature must be Witnessed by Two individuals, OR a Notary Public

I attest that I have made these decisions of my own free will and expect that my healthcare providers and surrogate decision makers will abide by them and make other decisions consistent with my directives as stated above.

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____

Address: _____

Witness: _____ Date: _____

Address: _____

OR

Acknowledgment State of _____

County of _____

The foregoing instrument was acknowledged before me this _____ (date) by _____ (name of person acknowledged)

Notary Public Signature _____

(SEAL)

Nebraska Emergency Treatment ORDERS

Name: _____ DOB: _____ DATE: _____

MEDICAL ORDERS AND ATTESTATION

Orders for Emergency Medical Services (EMS) or other first responders:

Resuscitation Status:

____ Attempt CPR (must select "Intubate" below)

____ **DO NOT** Attempt CPR (DNR)

Intubation Status:

____ Intubate if medically indicated

____ **DO NOT** Intubate (**non-invasive ventilation OK**)

Transportation:

____ Transport per protocol

____ **DO NOT** transport unless symptoms cannot be managed in current location

Medical Attestation:

I attest that I have discussed with the patient the choices they made on the reverse side of this form, and I have written the adjacent orders accordingly. In my opinion, the patient is competent and has capacity to make these decisions. I believe the patient understands that if they experience a life-limiting condition or accident, their decisions will apply to either situation.

_____ Date: _____

Signature of Physician, Nurse Practitioner or Physician Assistant

Printed Name: _____

License: _____

Phone: _____

DESCRIPTION AND AUTHORITY

The Nebraska Emergency Treatment Declaration and Orders document was created by Nebraska physicians and attorneys to improve patient and family participation in critical decision making. Page 1 is a "Treatment Declaration" for patients to express their right to accept or refuse medical care and treatment if they are unable to speak for themselves, in accordance with U.S. Common Law and the Nebraska Rights of the Terminally Ill Act (§20-404). **It is an Advance Directive and should be entered into the patient's medical record as such.** This form replaces any predated declarations, which may also be known as "living wills."

Page 2 is a set of Out-of-Hospital orders for Emergency Medical Services which are consistent with Nebraska EMS Protocol(s), and are written so that patients receive only the emergency treatments they desire.

INSTRUCTIONS FOR USE OF COMPLETED FORM

- This form is intended to follow the patient from location to location. When transferring a patient, keep a copy of the form, and send the original with the patient. The original form is on bright yellow paper. A copy of the original form is considered valid.
- The Treatment Declaration form should be presumed valid unless there is compelling evidence to suggest it has been altered. It is valid unless and until replaced by another Treatment Declaration or revoked by the patient, who may destroy it or write "revoked" across it with date and signature.
- Decisions can, and should, be revised when a change in the patient's medical condition warrants completion of a new form.
- The completed, witnessed Treatment Declaration may not be changed or altered. If the patient's directives change, a new form should be completed.
- Surrogate medical decision maker(s) are not allowed by Nebraska law to initiate or modify a Treatment Declaration. For a patient who lacks capacity, however, surrogates may make decisions consistent with the patient's best known wishes and current medical condition. A Declaration is considered the strongest evidence of a patient's wishes.
- Anyone who tampers with or withholds a Treatment Declaration document is subject to legal penalty.
- This form is completely voluntary. No one is required to complete a NETO form.
- This form is only available through licensed medical providers.

EMERGENCY CONTACTS

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone 1: _____ Phone 1: _____

Phone 2: _____ Phone 2: _____

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