DRAFT FORM

NETO

Nebraska Emergency Treatment Orders WORKSHEET

This worksheet does not become a legal declaration until **signed** and **notarized**.
Please talk with your doctor to complete the final form and orders for emergency medical treatment.

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.

version 1; approved: Aug. 2017