

General Policy and Procedure

Limitations to Life-Prolonging Therapy

The Washtenaw/Livingston MCA recognizes that certain patients will receive no medical benefit from the full spectrum of available emergency services. The patient's personal physician is optimally qualified to assist the patient in determining when further efforts to prolong life are futile. When these limitations are adequately documented, EMS personnel should honor the wishes of the patient. A written summary of the patient's wishes as signed by a physician is one form of adequate documentation. When operative, these directives should be attached to the Medical Incident Report.

The patient, his legal guardian, family members or the patient's physician may retract the patient's previously documented wishes. The prehospital provider will then honor the modified request. The prehospital provider may initiate appropriate treatment of the patient if the patient's wishes are unclear. Contact Medical Control for further treatment direction.

MCA Approved	11/96	06/99	11/03	
Implement	02/97	07/99	12/03	

**WASHTENAW/LIVINGSTON COUNTY MEDICAL CONTROL BOARD
LIMITATIONS TO LIFE-PROLONGING THERAPY**

This form must be available at the time of emergency treatment to be valid

PATIENTNAME: _____

DATE OF BIRTH: ____/____/____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIVATE _____ PHYSICIAN: _____

PHONE: (____) _____

DIAGNOSIS: _____

PREFERRED HOSPITAL: _____

NEXT OF KIN AND/OR LEGAL GUARDIAN: _____

PHONE: (____) _____

EFFECTIVE DATE: ____/____/____

LIMITATIONS TO LIFE-PROLONGING THERAPY (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> No Chest Compressions | <input type="checkbox"/> No Defibrillation/Cardioversion |
| <input type="checkbox"/> No Ventilatory Assistance | <input type="checkbox"/> No Endotracheal Intubation |
| <input type="checkbox"/> No Resuscitation Drugs | <input type="checkbox"/> No Pacemaker |
| <input type="checkbox"/> No Vasopressors | <input type="checkbox"/> No Oxygen |
| <input type="checkbox"/> No IV's | |
| <input type="checkbox"/> OTHER | |

CONSIDERATIONS:

I, _____, certify that I am the physician of record for _____. I certify that this patient suffers from a condition which is irreversible and irreparable. Based on these certifications and beliefs, the requested limitations to life-prolonging therapy are ethically, morally and legally appropriate.

Physician Signature

I, _____, understand and agree to the Washtenaw/Livingston County Medical Control Board procedure for the limitations to life-prolonging therapy. I understand and agree to the specific limitations requested.

Patient and/or Designee