

**Natural Dying Physician's Orders (NDPO): For Emergency First Responders (EMTs); healthcare providers in hospitals, nursing homes & hospices; family members; & others.**

First follow my orders to withhold the interventions below; then contact me. **Safeguard:** Competent patients can revoke any order to accept treatment that is potentially life-sustaining. To verify this order call: 1-888-765-7876. My "NATURAL DYING Physician's Orders" (NDPO) are based on the patient's "NATURAL DYING Advance Directive" (NDAD), attached, and on discussions that led to my understanding of his/her end-of-life preferences.

Patient's full name: \_\_\_\_\_  
 Patient's date of birth &/or patient number: \_\_\_\_\_  
 Patient's address and phone: \_\_\_\_\_

**DNR 1 DO NOT (ATTEMPT) RESUSCITATION. Do NOT call "911" for CPR.**  
 Patient considered and discussed alternatives, and now refuses **all** potentially life-sustaining treatments.  
 \_\_\_\_\_ MD initial Discontinue and do not restart cardiac pacemakers, defibrillators, or Left Ventricular Assist Devices.

**No IVs 2 NATURAL DYING PHYSICIAN'S ORDERS (NDPO) replaces Physician's Orders for Life-Sustaining Treatment for Intermediate/Full Treatment if in force. My orders are "COMFORT CARE ONLY."**  
**DO NOT REHYDRATE (DNH<sub>2</sub>O), No IVs:** Patient has clearly chosen Medical Dehydration. Re-hydration may prolong duration of suffering while dying. Eliminate pain & suffering with opioids and sedatives using routes that minimize fluid. Consider transdermal patches, sublingual drops, IM injections.  
**DO NOT INTUBATE (DNI).** Remove obstruction. Use suction, + pressure devices, oxygen, opioids.  
**DO NOT HOSPITALIZE (DNHOSP) unless Comfort Care cannot be provided in current setting;** eg, to pin a hip fracture or provide **Palliative Sedation**. If transfer is necessary, list physical risks eg, fragility of bones; psychological factors, eg, delusions, delirium, combativeness. List **facilities NOT desired:**  
 \_\_\_\_\_ MD initial  
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**DNA 3 DO NOT ADMINISTER ANTIBIOTICS – UNLESS NEEDED FOR COMFORT CARE.**  
 \_\_\_\_\_ MD initial ALWAYS CONTINUE ALL COMFORT CARE MEDICATIONS but minimize administration of fluids.

**DNAED 4 DO NOT ASSIST EATING & DRINKING (DNAED) BUT OFFER FOOD & FLUID.**  
**Always place food and fluid near the patient, if awake.** Respect patient's decision if repeatedly refused. Never force oral ingestion if patient turns head away, bites down on the straw or spoon, or spits out food. Respect patient's wish for Natural Dying and his/her prior authorization/agreement to empower Proxies to refuse all food & fluid over his/her objection. **Unless** patient explicitly indicated otherwise when competent, **fulfill patient's request for food & fluid even if s/he is mentally unable to make medical decisions.**  
 \_\_\_\_\_ MD initial

**SAFEGUARDS 5 BASIS FOR ORDERS: 1-4** represent the patient's competent preferences based on my \_\_\_/\_\_\_/\_\_\_ discussion with patient, review of his/her Criteria in NDAD & Planning Professional's opinion (if available). **Physician's** Signature: X \_\_\_\_\_; Print: \_\_\_\_\_; Phone: \_\_\_\_\_, e-mail: \_\_\_\_\_.

**6 SAFEGUARDS BEFORE IMPLEMENTING:** My initials represent my best attempts to discuss orders (if not, explain why) with the patient, \_\_\_\_\_ family members, and/or \_\_\_\_\_ close friends; & if needed: \_\_\_\_\_ MD initial Psychiatrist/counselor who assessed patient's ability to make medical decisions & ruled out emotional \_\_\_\_\_ MD initial & cognitive barriers (e.g., anorexia nervosa, treatable depression, dementia) to exercise sound judgment; \_\_\_\_\_ MD initial Physician stating patient has already received the maximum benefit from pain management/palliative care. (For names and contact information of individuals important to patient, see list in the attached NDAD.)

I, \_\_\_\_\_ (patient's printed name), was informed about Orders 1 - 4, above; I consent since they reflect my wishes. Signed: X \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 Physician's signature for patient's consent: X \_\_\_\_\_, printed name: \_\_\_\_\_; License #: \_\_\_\_\_; Phone: \_\_\_\_\_; Cell: \_\_\_\_\_; email: \_\_\_\_\_; City: \_\_\_\_\_  
 Physician's signature TO IMPLEMENT Orders 1 - 4: X \_\_\_\_\_; Date: \_\_\_/\_\_\_/\_\_\_

**Evaluation Copy**

## Natural Dying Advance Directive (NDAD): to refuse all life-sustaining treatment

The **Natural Dying Advance Directive** is the *pivotal* form of the “Plan Now; Die Later” ironclad strategy. It is for *only* those who wish to refuse *all* life-sustaining treatment if their future mental or physical condition ever meets *their criteria*. This **NDAD** is the basis for *actionable* **Natural Dying Physician’s Orders (NDPO) 1 - 4**. In the event of a *conflict* with other Advance Care Planning forms, **NDAD/NDPO** will prevail if these forms are most recently dated.

### Signatures to “PLAN NOW”:

The competent adult **patient** signs in “**A**” after being informed about the *process* of **Natural Dying**; for example, by sorting **My Way Cards**. The **patient** can: authorize a person to be his/her Proxy (Agent), which is recommended; **or** ask his/her Physician to decide *WHEN* it is time for **Natural Dying** based on the patient’s *criteria* (below).

To save the Physician time, a **Planning Professional** (a *trained* Nurse, Social Worker, Marriage Therapist, Nurse Practitioner, Physician Assistant, Pastoral Counselor, Psychologist, or Attorney) may conduct an *initial* informed consent discussion and assessment of decisional capacity, form an opinion, and then sign in “**B**.”

**A) To patient:** Have you considered and discussed alternatives to **Natural Dying** at the end of life? Yes/No. Do you refuse tube feeding and empower your Proxy and Physician to stop manual assistance for oral feeding and drinking? Yes/No. Do you authorize your future decision-makers to consider *your criteria* below, to decide *WHEN* it is time for **Natural Dying**? Yes/No. Do you agree to *disclose* this **NDPO/NDAD** form to all healthcare providers in all settings? Yes/No. If **ALL** your answers are **YES**, sign **one** of these **two** authorizing statements to indicate your **durable consent**: I select my **Physician** to honor my *criteria* to decide *WHEN* it is time for **Natural Dying**: X  **OR**: I select my **Proxy** to decide *WHEN* it is time for **Natural Dying**: X  **Evaluation Copy**. Enter *today’s date*: \_\_\_ / \_\_\_ / \_\_\_ . Is this **NDPO/NDAD** your *most recent* expression of end-of-life wishes? Yes/No. Whom do you designate as your proxy to make your healthcare decisions? \_\_\_\_\_; his/her phone: \_\_\_\_\_, e-mail: \_\_\_\_\_. Have you listed alternate proxies on an additional sheet or a *previously dated* Proxy Directive? Yes/No. Did you sign a **Natural Dying Agreement**? Yes/No. Should your Physician/Proxy **wait** to distribute copies of this **NDPO/NDAD** *until it is time* to implement its orders? Yes/No. Did you express your specific wishes for Advanced Dementia by creating a **My Way Cards—Living Will**? Yes/No. Physician providing comfort care: \_\_\_\_\_; Psychiatrist/psychologist/counselor: \_\_\_\_\_. Others (religious/spiritual leader, attorney, hospice worker, advocates, caregivers, end-of-life organization): \_\_\_\_\_

List any individuals you **DISQUALIFY** from making medical decisions for you: \_\_\_\_\_

→ **Notary public** or **qualified witnesses** *must sign* using a separate (“acknowledgment/witness”) page.

**B) To the Planning Professional:** If you informed patient about **Natural Dying** on \_\_\_ / \_\_\_ / \_\_\_, and formed the opinion that the patient had the mental capacity to make end-of-life decisions, **print** YOUR name & degree: \_\_\_\_\_; **Sign:** X \_\_\_\_\_, Phone: \_\_\_\_\_, e-mail: \_\_\_\_\_.

### Signatures to “DIE LATER”:

The patient wants future decision-makers to consider these *CRITERIA* to decide if it is time for **Natural Dying**:

- Is terminally ill and has unbearable and untreatable pain or suffering; or
- Meets the *criteria selected in My Way Cards—Living Will* for *Advanced Dementia* or *terminal illness*; or
- Has an exceedingly low chance of returning to a level of health that would permit survival independent of continuing intensive medical treatment as a hospital or skilled nursing facility would provide; or
- Has reached the clinical point discussed with \_\_\_\_\_ on (date) \_\_\_ / \_\_\_ / \_\_\_, or previously wrote in other Advance Directive forms and/or recorded on audio or video dated \_\_\_ / \_\_\_ / \_\_\_ .

**C) To the Proxy:** If the patient previously authorized you to decide *WHEN* it is time for **Natural Dying**, and *NOW* you believe that time has come—based on the above *criteria* and your **current consultations with treating physicians**, and you have agreed to try to find a *Physician willing to implement the attached NDPO*, then **Sign:** X \_\_\_\_\_; **Print:** \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_ .

**D) To the Implementing Physician:** If you agree it is *NOW* time for **Natural Dying**, then sign and date the **NDPO** (on the *other side of this sheet*) in the *box* after the words, “**TO IMPLEMENT Orders 1 - 4**.”