(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____
Allergies with reaction type:_____

DO NOT RESUSCITATE (DNR) ORDERS **Version 5 5/16/2014**
ALL ORDERS MUST INCLUDE DATE, TIME, AND PHYSICIAN SIGNATURE

(CHECK TO INDICATE ORDER)

1. ___ **DNR**
In the event of a cardiac, pulmonary, or cardiopulmonary arrest, no resuscitative measures will be initiated, including:
Mechanical ventilation
Cardioversion/defibrillation
Endotracheal intubation
Chest compression
The administration of emergency medications or fluids

OR

2. ___ **LIFE SUPPORT MEASURES WILL BE LIMITED IN THE FOLLOWING WAY**
In the event of a cardiac, pulmonary or cardiopulmonary arrest:
___ No intubation, mechanical ventilation
___ No chest compressions
___ No emergency medications and fluids
___ No defibrillation, cardioversion
___ No _____

3. ___ **COMFORT ONE** (Request form for signature-required for intercampus transfers).

All DNR orders for patients in a critical care unit are reviewed prior to or at the time of transfer.

Provider Signature:_____Date:_____Time:_____