

COMFORT CARE ORDERS *

Date: _____

Time: _____

DATE	NURSING UNIT
MR, MISS, MRS	UNIT NUMBER
SURNAME	GIVEN NAME
DOCTOR	(PLEASE USE BLOCK CAPITALS)
SEX	AGE

1. Patient preparation:

DNA CPR

IV Fluid TKVO

- Discontinue all investigations
- Discontinue all bloodwork
- Discontinue nutritional support
- Discontinue renal replacement therapy
- Remove devices not necessary for comfort

Specify: _____

2. Medication:

- Discontinue all medication except vasopressor/inotropic support:

For management of pain, agitation and/or respiratory distress:	
Morphine:	0 - _____ mg/hr infusion prn, _____ mg IV bolus prn
Midazolam:	0 - _____ mg/hr infusion, prn _____ mg IV bolus prn

Other medications: _____

3. Removal of Life Supportive Measures:

When family and patient are prepared:

- Discontinue vasopressor/inotropic support
- Discontinue mechanical ventilation
- Extubate to room air

4. Supplemental orders: _____

Signature _____

* See End of Life Resource Binder