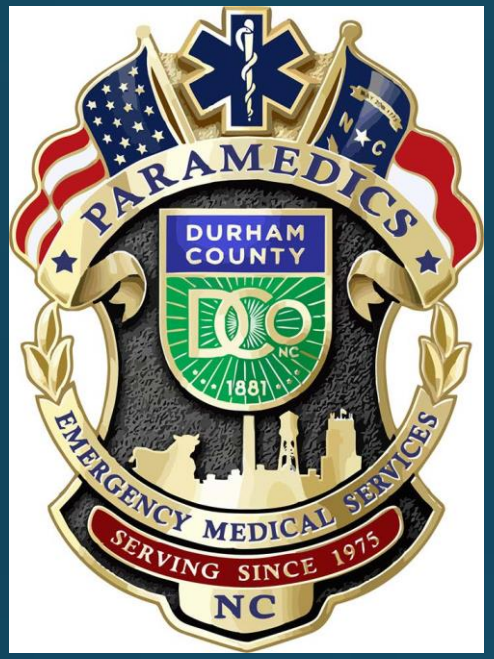
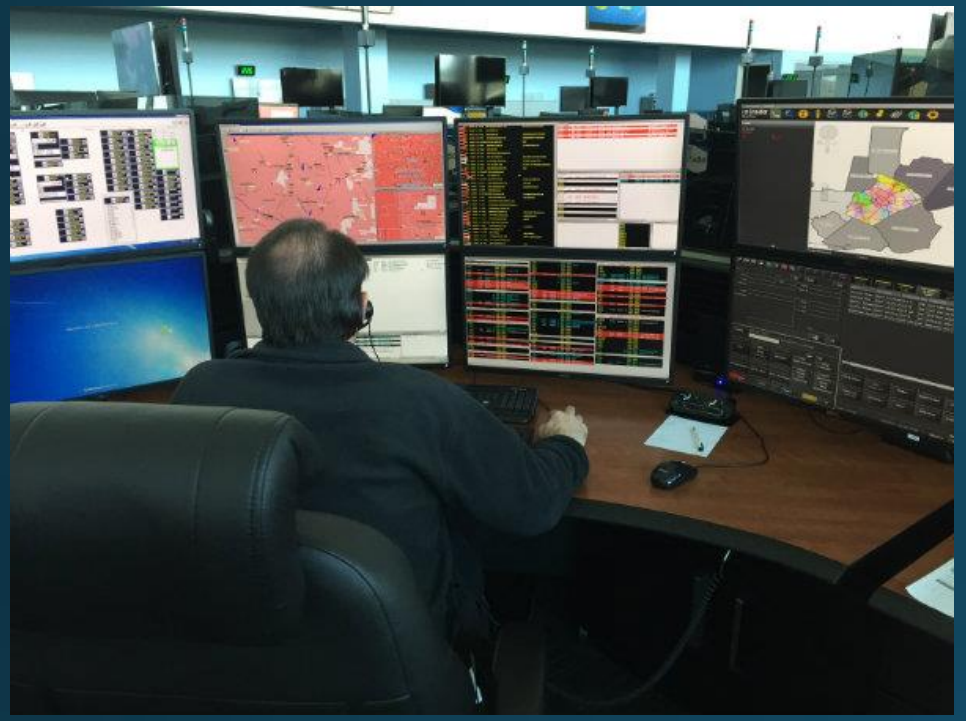


Helping EMS Help You:

How to Prepare for a 911 Emergency

- What to expect when you call 911
- How to use the Vial of Life
- The importance of Advanced Directives



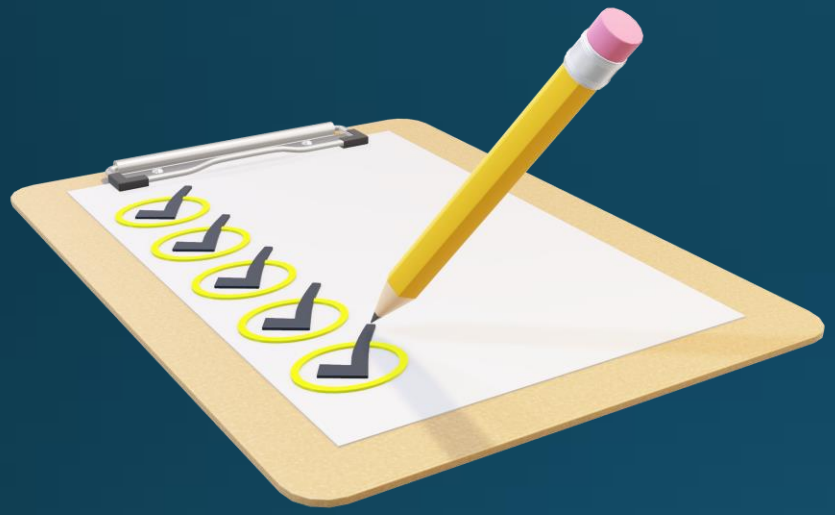
Call 911
or
919-560-4600

"Durham 911.

What is the location of your emergency?"

https://durhamnc.gov/435/Emergency-Communications

What Happens Next



What EMS Needs to Know

Name

- How you might be registered at the hospital
- Date of birth

What happened?

- Why do you need an ambulance?
- When did your symptoms start?
- How long has it been going on? Have you ever had this happen before?
- What have you done to feel better?

Allergies/Medications

- Medication allergies (most important)
- Names of medications (including dosages)
- Certain medications – last time you took it

What hospital?

- You may not always get to choose

Health insurance

- Yes…there is a bill!

Other information

- Social security number
- Your phone number
- Who can we call for you? (Next of kin)

Vial of Life

Durham County EMS **VIAL OF LIFE** Information Form

GENERAL INFORMATION

Name: _____ Date filled out: ____/____/____

Address: _____

Phone: (____) ____ - _____ Date of birth: ____/____/____ SSN: _____ - _____ - _____

Hospital Preference: _____

MEDICAL HISTORY

- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Atrial Fibrillation/Irregular Heart Beat
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ C.O.P.D.
- ☐ Emphysema
- ☐ Diabetes
- ☐ Kidney Disease (Dialysis Y N)
- ☐ Liver Disease
- ☐ Cancer (type)
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Blood Thinner/Anticoagulant
- ☐ Dementia/Alzheimer's
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric (type)
- ☐ Other _____

_____

OTHER MEDICAL HISTORY NOTES/ASSISTIVE DEVICES

_____
_____
_____

ALLERGIES (TO MEDICATIONS OR OTHERWISE)

_____
_____
_____

DOCTOR

Name: _____ Phone Number: _____

ADVANCED DIRECTIVES, M.O.S.T. OR DNR including LOCATION

DNR Location: _____

M.O.S.T Location: _____

This program is sponsored by Duke Regional Hospital

Durham County EMS **VIAL OF LIFE** Information Form

MEDICATION	DOSAGE

HEALTH INSURANCE POLICY INFORMATION

_____
_____
_____

EMERGENCY CONTACTS

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

OTHER INFORMATION

_____
_____
_____

To obtain additional forms please call 919-560-8285.

This program is sponsored by Duke Regional Hospital

Durham County EMS **VIAL OF LIFE** Information Form

GENERAL INFORMATION

Name: _____ Date filled out: ____/____/____

Address: _____

Phone: (____) ____ - _____ Date of birth: ____/____/____ SSN: _____ - _____ - _____

Hospital Preference: _____

MEDICAL HISTORY

- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Atrial Fibrillation/Irregular Heart Beat
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ C.O.P.D.
- ☐ Emphysema
- ☐ Diabetes
- ☐ Kidney Disease (Dialysis Y N)
- ☐ Liver Disease
- ☐ Cancer (type)
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Blood Thinner/Anticoagulant
- ☐ Dementia/Alzheimer's
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric (type)
- ☐ Other _____
  _____

OTHER MEDICAL HISTORY NOTES/ASSISTIVE DEVICES

_____

_____

_____

ALLERGIES (TO MEDICATIONS OR OTHERWISE)

_____

_____

_____

DOCTOR

Name: _____ Phone Number: _____

ADVANCED DIRECTIVES, M.O.S.T. OR DNR including LOCATION

DNR Location: _____

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Durham County EMS **VIAL OF LIFE** Information Form

MEDICATION	DOSAGE

HEALTH INSURANCE POLICY INFORMATION

_____

_____

_____

EMERGENCY CONTACTS

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

OTHER INFORMATION

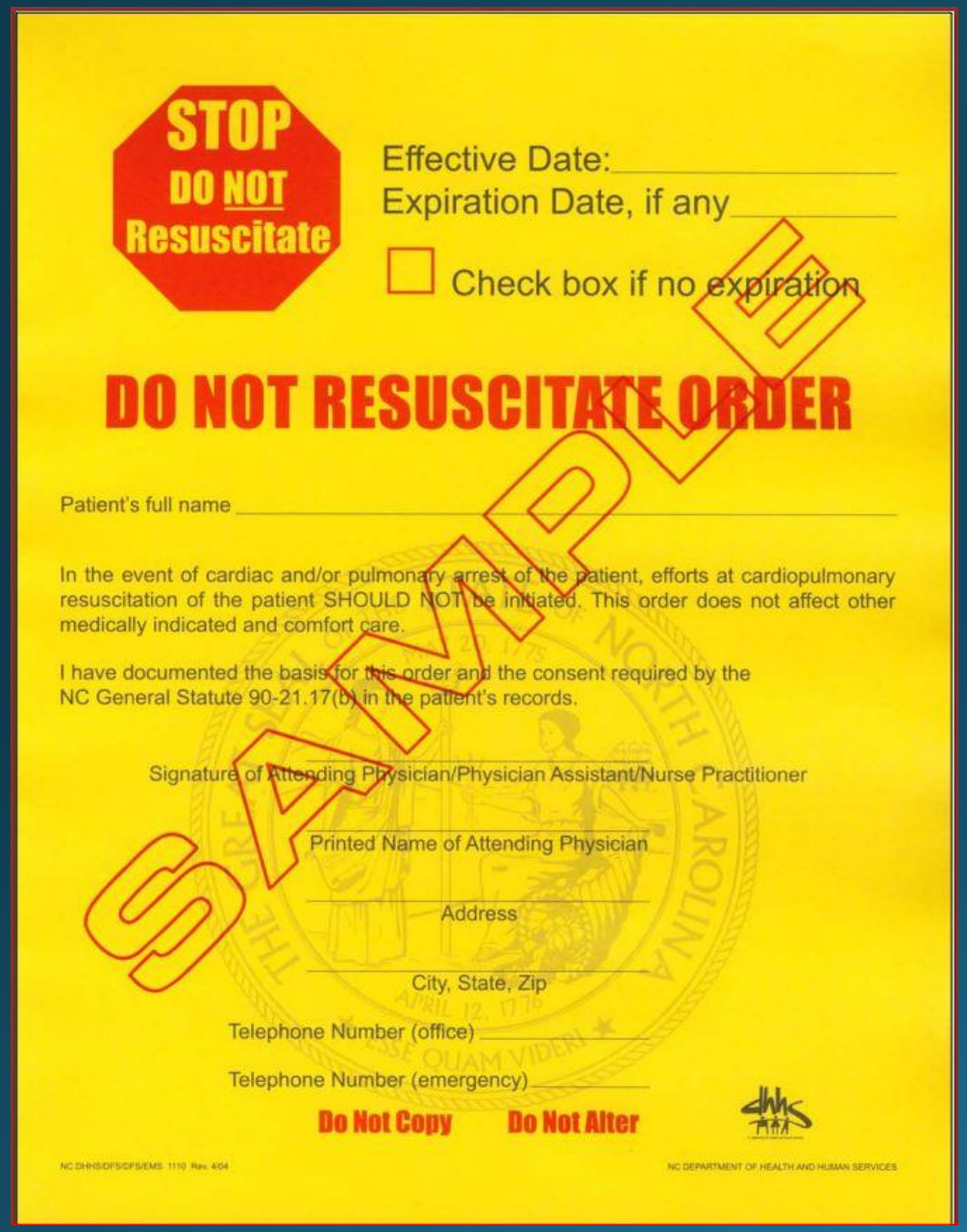
_____

_____

_____

To obtain additional forms please call 919-560-8285.

This program is sponsored by Duke Regional Hospital



STOP
DO NOT
Resuscitate

Effective Date: _____
Expiration Date, if any _____

☐ Check box if no expiration

DO NOT RESUSCITATE ORDER

SAMPLE

Patient's full name _____

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

_____
Signature of Attending Physician/Physician Assistant/Nurse Practitioner

_____
Printed Name of Attending Physician

_____
Address

_____
City, State, Zip

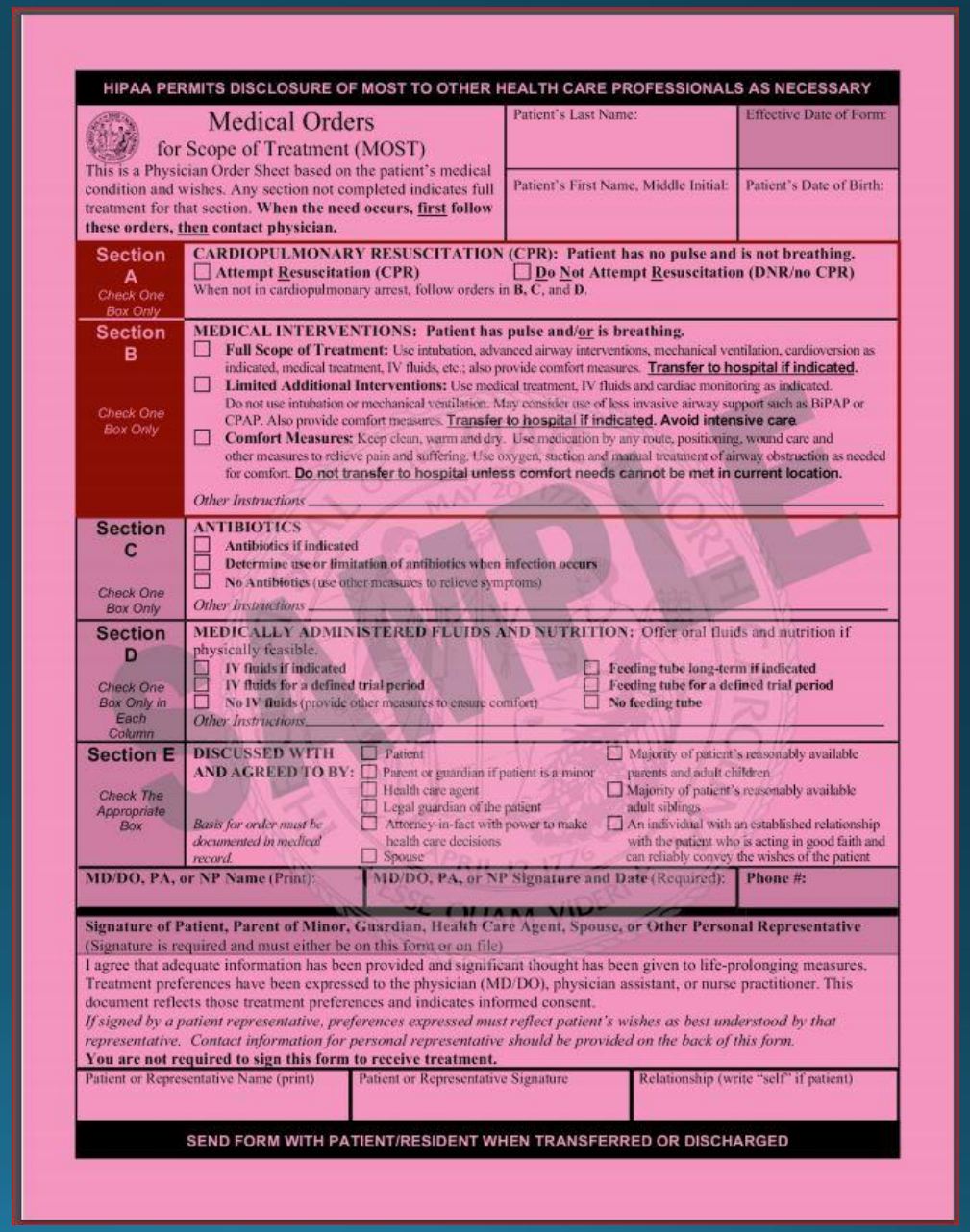
Telephone Number (office) _____

Telephone Number (emergency) _____

Do Not Copy **Do Not Alter**

NC DHHS/DFS/DFS/EMS 1110 Rev. 4/04

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:	Effective Date of Form:
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if indicated**
☐ **Determine use or limitation of antibiotics when infection occurs**
☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated**	☐ **Feeding tube long-term if indicated**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **No IV fluids** (provide other measures to ensure comfort)	☐ **No feeding tube**

Other Instructions _____

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY:

☐ Patient	☐ Parent or guardian if patient is a minor	☐ Majority of patient's reasonably available parents and adult children
☐ Health care agent	☐ Legal guardian of the patient	☐ Majority of patient's reasonably available adult siblings
☐ Attorney-in-fact with power to make health care decisions	☐ Spouse	☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print):	**MD/DO, PA, or NP Signature and Date** (Required):	**Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

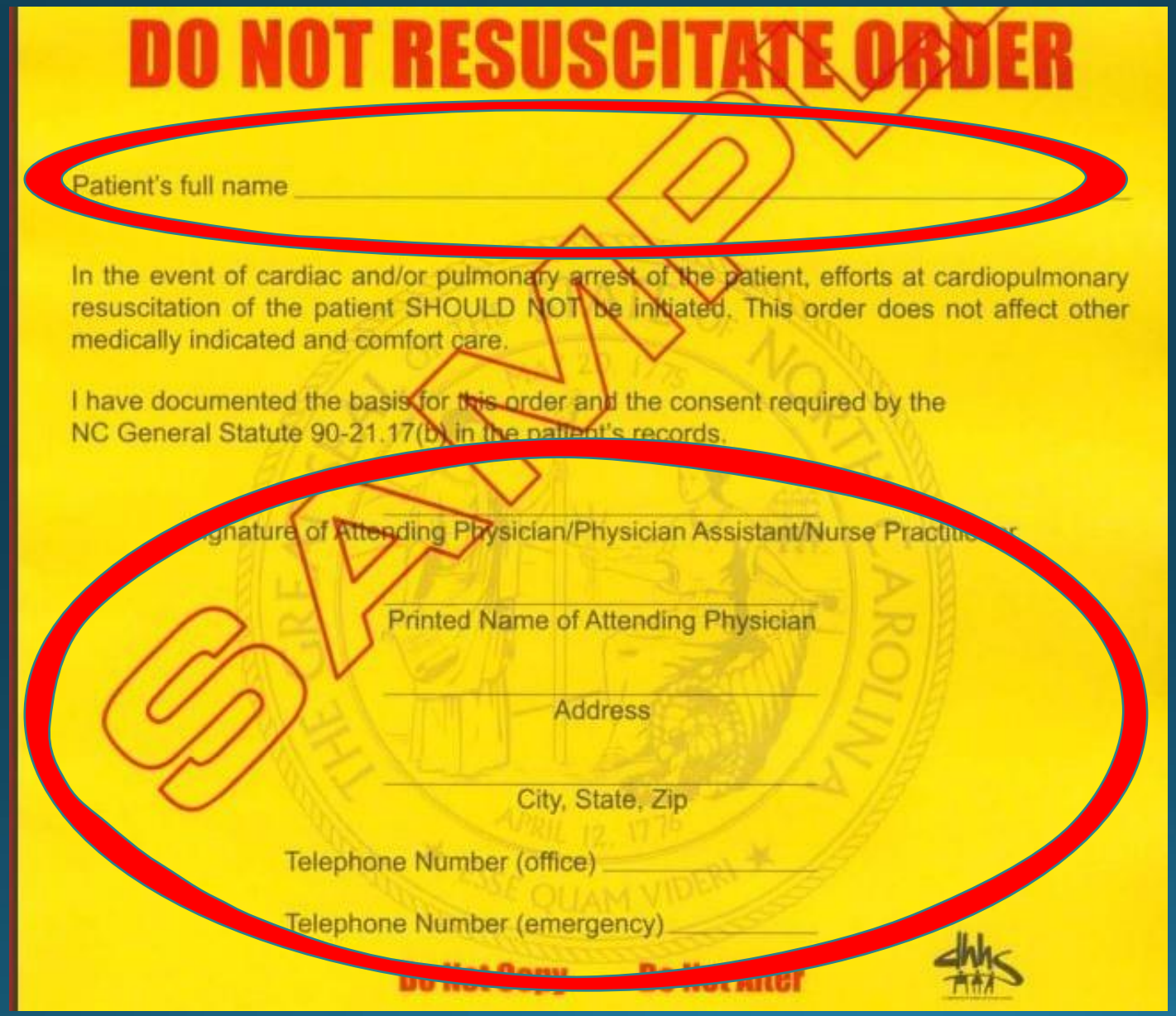
You are not required to sign this form to receive treatment.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE


STOP
DO NOT
Resuscitate
Effective Date:
Expiration Date, if any
Check box if no expiration
DO NOT RESUSCITATE ORDER


DO NOT RESUSCITATE ORDER
SAMPLE
Patient's full name
In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.
I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.
ignature of Attending Physician/Physician Assistant/Nurse Practitioner
Printed Name of Attending Physician
Address
City, State, Zip
Telephone Number (office)
Telephone Number (emergency)

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders
for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:	Effective Date of Form:
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A

Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B

Check One Box Only

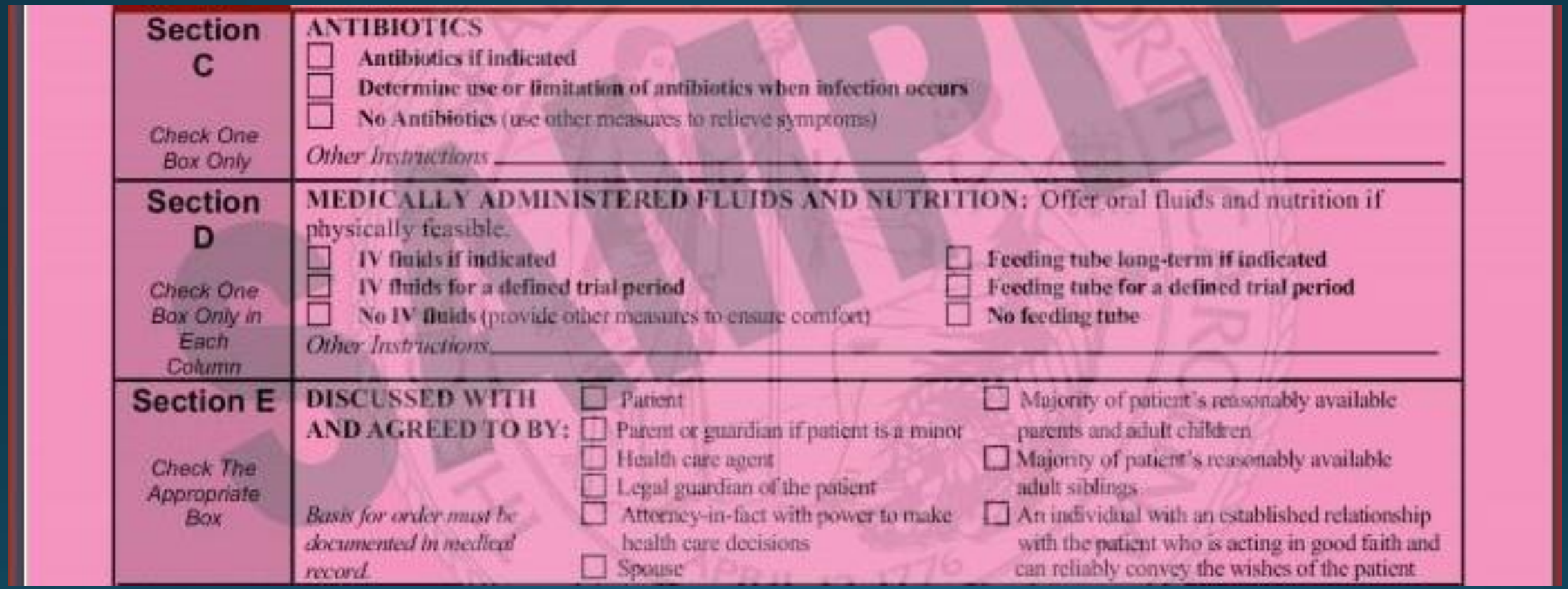
MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☑ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☑ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☑ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____



Section C

Check One Box Only

ANTIBIOTICS

- ☐ **Antibiotics if indicated**
- ☐ **Determine use or limitation of antibiotics when infection occurs**
- ☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D

Check One Box Only in Each Column

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

- ☐ **IV fluids if indicated**
- ☐ **IV fluids for a defined trial period**
- ☐ **No IV fluids** (provide other measures to ensure comfort)
- ☐ **Feeding tube long-term if indicated**
- ☐ **Feeding tube for a defined trial period**
- ☐ **No feeding tube**

Other Instructions _____

Section E

Check The Appropriate Box

DISCUSSED WITH AND AGREED TO BY:

Basis for order must be documented in medical record.

- ☐ Patient
- ☐ Parent or guardian if patient is a minor
- ☐ Health care agent
- ☐ Legal guardian of the patient
- ☐ Attorney-in-fact with power to make health care decisions
- ☐ Spouse
- ☐ Majority of patient's reasonably available parents and adult children
- ☐ Majority of patient's reasonably available adult siblings
- ☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

MD/DO, PA, or NP Name (Print):	MD/DO, PA, or NP Signature and Date (Required):	Phone #:

Signature of Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N. C. G en. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

SAMPLE

Review of MOST

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

NCDHHS/DHSR/OEMS
112

North Carolina Department of Health and Human Services • Division of Health Service Regulation • Office of Emergency Medical Services
www.ncdhhs.gov • www.ncdhhs.gov/dhsr/EMS/ems.htm
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OTHER MEDICAL HISTORY NOTES/ASSISTIVE DEVICES

_____

_____

_____

ALLERGIES (TO MEDICATIONS OR OTHERWISE)

_____

_____

_____

DOCTOR

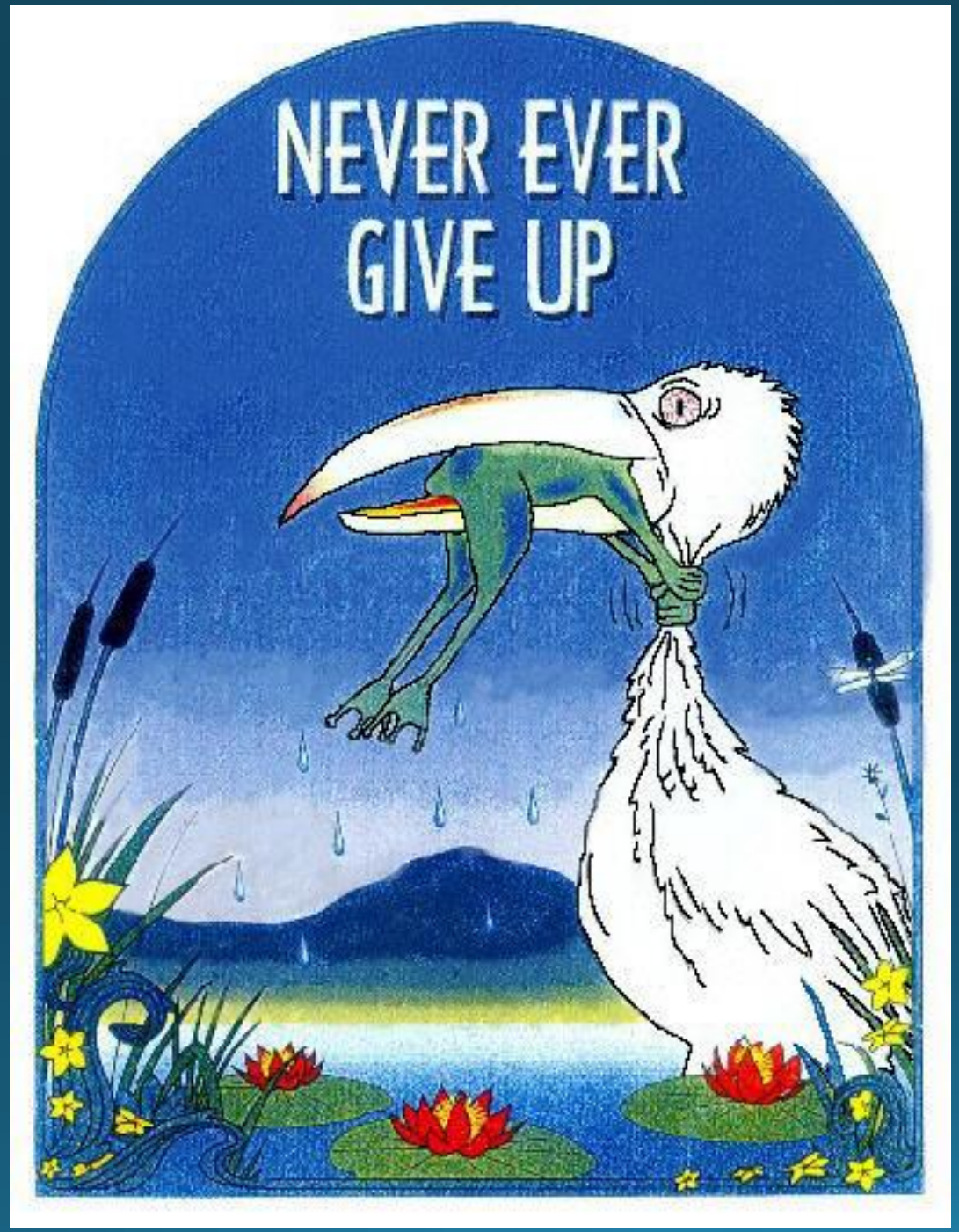
Name: _____ Phone Number: _____

ADVANCED DIRECTIVES, M.O.S.T. OR DNR including LOCATION

DNR Location: _____

M.O.S.T Location: _____

This program is sponsored by Duke Regional Hospital


NEVER EVER
GIVE UP