STATE BOARD OF HEALTH
ADMINISTRATIVE CODE

CHAPTER 420-5-19
ADVANCE DIRECTIVES

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420-5-19-.01 <u>Advance Directives</u>. Surrogate health care decision makers, as authorized by Act 97-187, shall complete the form attached hereto as Appendix 1 which, when properly completed and duly notarized, shall constitute the certification of the surrogate as required by the act. This form is to be used in fulfillment of the purposes of Act 97-187.
Author: Rick Harris
Statutory Authority: Act No. 97-187.
History: **New Rule:** Filed August 20, 1997; effective September 24, 1997.

420-5-19-.02 <u>Portable Physician Do Not Attempt Resuscitation Orders.</u>

(1) **Definitions.**

(a) **Do Not Attempt Resuscitation (DNAR) Order.** A physician's order that resuscitative measures not be provided to a person under a physician's care in the event the person is found with cardiopulmonary cessation. A DNAR order would include, without limitation, physician orders written as "do not resuscitate," "do not allow resuscitation," "do not allow resuscitative measures," "DNAR," "DNR," "allow natural death," or "AND." A DNAR order must be entered with the consent of the person, if the person is competent; or in accordance with instructions in an advance directive if the person is not

competent or is no longer able to understand, appreciate, and direct his or her medical treatment and has no hope of regaining that ability; or with the consent of a health care proxy or surrogate functioning under the provisions of Title 22, Chapter 8A, Code of Alabama 1975; or instructions by an attorney in fact under a durable power of attorney that duly grants powers to the attorney in fact to make those decisions described in Section 22-8A-4(b)(1), Code of Alabama 1975.

(b) **Portable Physician DNAR Order.** A DNAR order entered into the medical record by a physician using the required form designated by this rule and substantiated by completion of all applicable sections of the form.

(2) Physicians intending to enter a portable physician DNAR order shall utilize the form attached hereto as Appendix 2 which, when properly completed and executed, shall constitute the portable physician DNAR order as authorized by Act 2016-96. An electronic version of the form with same content may be utilized.

(3) Portable physician DNAR orders issued in accordance with this rule shall remain valid and in effect until revoked pursuant to Section 22-8A-5, Code of Alabama 1975, or by other recognized means. Qualified emergency medical services personnel and licensed health care practitioners in any facility, program, or organization including those operated, licensed, or owned by another state agency are authorized to follow portable physician DNAR orders that are available, known to them, and executed in accordance with this rule.

(4) If a person with a portable physician DNAR order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the order to the receiving facility prior to or during the transfer. The transferring facility shall assure that a copy of the order accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the order a part of the patient's permanent medical record.

(5) This rule does not prevent, prohibit, or limit a physician from issuing a facility-specific written order, other than a portable physician DNAR order, not to resuscitate a patient in accordance with accepted medical practices in the event of

cardiopulmonary cessation. A facility-specific DNAR order is not a portable physician DNAR order and does not transfer with the patient to another health care facility.

(6) DNAR orders issued before the effective date of this rule shall remain valid as a facility-specific DNAR order.

Author: Walter T. Geary Jr., M.D.

Statutory Authority: Act 2016-96

History: **New Rule**: Filed August 19, 2016; effective October 3, 2016.

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APPENDIX I

CERTIFICATION OF HEALTH CARE DECISION SURROGATE

PATIENT'S NAME: ________________________________
SURROGATE'S NAME:________________________________

I certify that:

(a) I am at least nineteen years old.

(b) The patient whose name is given above either has not, to my knowledge, made an advance directive for health care (living will or durable power of attorney), or the patient has executed an advance directive for health care, but the document fails to address his or her present circumstances.

(c) I have consulted with the physician who is now overseeing the patient's care.

(d) I am qualified to act as a surrogate health care decision maker for this patient because:

I. My relationship to the patient is the one indicated by checkmark below.

II. I have spoken to or attempted to speak to all other adults, if there are any, who fit into my category, and to all those who fit into a higher category (on the list below, a higher category is one listed before my category). Each such person that I spoke to has either agreed that I may act as surrogate, or has expressed no objection to my acting as surrogate.

III. If I have not spoken to any such person, it is because the person is in an unknown location, or because he or she is in a location so remote that he or she cannot, as a practical matter, be contacted in a timely fashion, or because he or she has been adjudged incompetent and remains incompetent today.

_______1. I am the judicially-appointed guardian of the patient. My guardianship appointment specifically gives me the authority to make health care decisions for the patient.

_______2. I am the husband or wife of the patient.

_______3. I am a child of the patient.

_______4. I am a parent of the patient.

_______5. I am a brother or sister of the patient.

_______6. I am another person related to the patient by blood. To my knowledge, the patient has no living relatives, or the patient's closer living relatives either cannot or will not serve as surrogates. I am the patient's ________________________.

_______7. The patient has not known relatives who are able and willing to act as surrogate. I am a representative of the ethics committee at the facility where the patient is being treated or I am a representative of some other committee duly appointed to make health care decisions for this patient.

(e) I understand that under the laws of Alabama certification on this form of any information known by me to be false is a class C felony, which has a penalty of up to ten years imprisonment, and a fine of up to $5,000.

____
Signature Of Surrogate

Sworn to (or affirmed) and subscribed before me this ___ day of ________, _____.

____
Notary Public

Author: Rick Harris
Statutory Authority: Act No. 97-187.
History: **New Rule:** Filed August 20, 1997; effective September 24, 1997.

APPENDIX II

Alabama Portable Physician Do Not Attempt Resuscitation Order
No CPR/ Allow Natural Death

____

Patient/Resident Full Name (PRINT) and Date of Birth:

Instructions. This order is valid only if Section I, II, III, OR IV is completed AND a physician has completed Section V.

Section I. Patient/Resident Consent.

I, the undersigned patient/resident, direct that resuscitative measures be withheld from me in the event of cardiopulmonary cessation. I have discussed this decision with my physician, and I understand the consequences of this decision.

____________________________ ____________________

Signature of Patient/Resident Date

Section II. Incompetent Patient/Resident with DNAR instructions in Advance Directive.

The patient/resident is not competent or is no longer able to understand, appreciate, and direct his/her medical treatment and has no hope of regaining that ability. A duly executed Advance Directive for Health Care with instructions that no life sustaining treatment be provided was previously authorized by the patient/resident and is part of his/her medical record.

____

Signature of provider or facility representative

____________________________ ____________________

Print Name Date

Section III. Health Care Proxy or Attorney-in-Fact Consent.

I, the undersigned, am the health care proxy or attorney-in-fact designated by the patient/resident to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/resident. I hereby direct that resuscitative measures be withheld from the patient/resident in the event of cardiopulmonary cessation. A copy of the proxy or attorney-in-fact designation (e.g., living will, power of attorney, etc.) has been made part of the patient/resident's medical record.

____

Signature of Proxy or Attorney-in-Fact

____________________________ ____________________

Print Name Date

Section IV. Surrogate Consent.

I, the undersigned, am the surrogate certified to make decisions, in consultation with the attending physician, regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/resident. After consultation with the attending physician, I hereby direct that resuscitative measures be withheld from the patient/resident in the event of cardiopulmonary cessation. I believe that this decision conforms as closely as possible to what the patient/resident would have wanted. I make this decision in good faith and without consideration of the financial benefit or burden which may accrue to me or to the health care provider as a result of this decision. A copy of the Certification of Health Care Decision Surrogate has been made part of the patient/resident's medical record.

____
Signature of Surrogate

______________________________ ____________________
Print Name **Date**

Section V. Physician Authorization.

Based on the information above, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold resuscitative measures, i.e., cardiopulmonary resuscitation, chest compression, endotracheal intubation and other advanced airway management, artificial ventilation, cardiac resuscitative medications, and cardiac defibrillation, in the event of cardiopulmonary cessation in the patient/resident.

I further direct the implementation of all reasonable comfort care such as oxygen, suction, control of bleeding, administration of pain medication by personnel so authorized, and other therapies to provide comfort and alleviate suffering by the patient/resident; and to provide support to the patient, family members, friends, and others present.

____
Signature of Physician

______________________________ ____________________
Print Name **Date**

Author: Walter T. Geary Jr., M.D.
Statutory Authority: Act 2016-96.
History: **New Rule:** Filed August 19, 2016; effective October 3, 2016.