**Do Not Resuscitate (DNR) and Withhold/Withdraw Life Sustaining Treatment Form**

**Decision-Maker’s Name:** ________________________________________________

Relationship to patient:  □ Self  □ Health Care Agent  □ Legal Surrogate

Oral or Signed Consent:  Signature: ____________________________ Date: __________________

The patient/decision maker has been fully informed about the medical condition and has given consent to:

- ☐ A DNR order. Withhold all resuscitation measures if a cardiac or pulmonary arrest occurs.

- ☐ A DNR order with the following limits or exceptions: _______________________________________________

- ☐ An order to withhold or withdraw the following other life sustaining treatment(s): ______________________.

☐ The patient made this decision prior to losing capacity.

**Adult Witnesses:** The decision maker gave oral/written consent in our presence (including patient’s oral prior decision if applicable).

1st Witness’ Name______________________________ Date_________________

2nd Witness’ Name______________________________ Date_________________

**Capacity:** Notification of incapacity shall be made to the patient if the patient can comprehend the information. Findings of incapacity shall be given to the health care agent or surrogate. To a reasonable degree of medical certainty (check one):

- ☐ The patient has decisional capacity.

- ☐ The patient lacks decisional capacity due to __________________________________________

The duration of incapacity is expected to be:  ☑ temporary  ☐ prolonged  ☐ permanent.

Physician Signature______________________________ Date_________________

Concurring Health Care Provider____________________ Date_________________

**Medical Condition:** Treatment would impose burden and to a reasonable degree of medical certainty the patient has (check one):

- ☐ An illness or injury which is expected to cause death within six months regardless of treatment.

- ☐ Permanent unconsciousness.

- ☐ An irreversible or incurable condition such that treatment would impose pain, suffering or other burden.

Physician Signature______________________________ Date_________________

Concurring Health Care Provider____________________ Date_________________

☐ Order for DNR

☐ Order to withhold/withdraw the following other life sustaining treatments: ______________________

Physician Signature______________________________ Date_________________

Concurring Health Care Provider____________________ Date_________________