

## 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).

1<sup>st</sup> Witness' Name \_\_\_\_\_ Date \_\_\_\_\_

2<sup>nd</sup> 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 \_\_\_\_\_