

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

Decision-Maker's Name: _____ Telephone: _____

Relationship to patient: Self Health Care Agent Legal Surrogate

Oral or Signed Consent: Signature: _____ Date/Time: _____

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

Order for DNR

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

 Physician Name _____ Signature _____ Date _____

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 Name _____ Signature _____ Date _____

Concurring Health Care Provider Name _____ Signature _____ Date _____

Medical Condition: Treatment would impose an extraordinary burden and to a reasonable degree of medical certainty the patient has (document one for patients without capacity and without a health care agent):

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 Name _____ Signature _____ Date _____

Concurring Physician Name _____ Signature _____ Date _____