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

<table>
<thead>
<tr>
<th>Decision-Maker’s Name:</th>
<th>Telephone: ____________________________</th>
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</thead>
<tbody>
<tr>
<td>Relationship to patient:</td>
<td>[ ] Self  [ ] Health Care Agent  [ ] Legal Surrogate</td>
</tr>
<tr>
<td>Oral or Signed Consent:</td>
<td>Signature: ____________________________  Date/Time: ____________________________</td>
</tr>
</tbody>
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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 ____________________________