Mount Sinai

The Mount Sinai Hospital
One Gustave L. Levy Place
New York, NY 10029-6574

DOCUMENTATION SHEET #2
ADULT PATIENT--THERAPEUTIC EXCEPTION

Directions: This Documentation Sheet sets forth in consecutive order the steps that must be followed before writing a DNR ORDER or NON-HOSPITAL DNR ORDER for an ADULT patient who would suffer an immediate and severe injury from a discussion of CPR. Words that appear in the directions in all capital letters are defined in the DNR Policy. When completed, this Sheet must be placed in the patient's medical record.

Step One

The RESPONSIBLE PHYSICIAN must determine that the patient would suffer immediate and severe injury from a discussion of CPR, and must then ascertain the wishes of the patient to the extent possible without subjecting the patient to risk.

Determination of Injury

I have determined to a reasonable degree of medical certainty that the patient would suffer immediate and severe injury from a discussion of CPR because ____
________________________________. I have ascertained the wishes of the patient to the extent possible without subjecting the patient to risk.

________________ ________________________________ ________________________________
Date Print Name of RESPONSIBLE PHYSICIAN Signature of RESPONSIBLE PHYSICIAN

Step Two

A CONCURRING PHYSICIAN must agree with the determination that the patient would suffer immediate and severe injury from a discussion of CPR.

CONCURRING PHYSICIAN's Statement

I have personally examined the patient and have determined to a reasonable degree of medical certainty that the patient would suffer immediate and severe injury from a discussion of CPR.

________________ ________________________________ ________________________________
Date Print Name of CONCURRING PHYSICIAN Signature of CONCURRING PHYSICIAN

Step Three

The RESPONSIBLE PHYSICIAN must determine whether the patient PREVIOUSLY CONSENTED to a DNR ORDER. If the patient PREVIOUSLY CONSENTED, documentation of that consent must be attached to this Documentation Sheet. The RESPONSIBLE PHYSICIAN must review the PREVIOUS CONSENT and determine that any specified medical conditions described in that document exist.

Determination of Medical Conditions

I have personally examined the patient and have determined to a reasonable degree of medical certainty that the medical conditions described in patient's previous consent to a DNR ORDER exist.

Date	Print Name of RESPONSIBLE PHYSICIAN	Signature of RESPONSIBLE PHYSICIAN

Step Four (If the patient PREVIOUSLY CONSENTED, proceed to Step Seven.)

If the patient has not PREVIOUSLY CONSENTED to a DNR ORDER, the RESPONSIBLE PHYSICIAN must determined that the patient is suitable for the issuance of a DNR ORDER. A CONCURRING PHYSICIAN must agree with this determination.

Determination of Suitability for DNR ORDER

I have personally examined the patient and have determined to a reasonable degree of medical certainty that: (check as applicable)

____a. the patient has a terminal condition; or
____b. resuscitation would be medically futile; or
____c. resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient.

Date	Print Name of RESPONSIBLE PHYSICIAN	Signature of RESPONSIBLE PHYSICIAN
Date	Print Name of CONCURRING PHYSICIAN	Signature of CONCURRING PHYSICIAN

Step Five

If there is no evidence that the patient PREVIOUSLY CONSENTED to a DNR ORDER, the RESPONSIBLE PHYSICIAN must determine whether the patient has appointed a HEALTH CARE AGENT, or if not, who is the proper SURROGATE. The HEALTH CARE AGENT or SURROGATE must be selected from the following list, in the order of priority listed.

a. a HEALTH CARE AGENT
b. an INDIVIDUAL DESIGNATED BY THE PATIENT
c. the court appointed committee or guardian of the patient
d. the spouse
e. a son or daughter, aged 18 or older
f. a parent
g. a brother or sister, aged 18 or older
h. a CLOSE FRIEND

Name of HEALTH CARE AGENT or SURROGATE ______________________
Relationship to patient ______________________

Step Six

The HEALTH CARE AGENT or SURROGATE must give oral or written consent to a DNR ORDER at or about the time the DNR ORDER is to be written. Oral consent must be given during hospitalization in the presence of two witnesses, one of whom must be on the medical staff of the Hospital.
[In the case of a NON-HOSPITAL DNR ORDER, the physician witness must be the RESPONSIBLE PHYSICIAN.]

Witness' Statement

The HEALTH CARE AGENT or SURROGATE has expressed orally in my presence the decision to consent to a DNR ORDER, subject to the following conditions or limitations (if any):

1. Consent not applicable during a surgical procedural or during recovery period after a surgical procedure (indicate if not applicable).
2. ______________________________.
3. ______________________________.

Date	Print Name of Witness	Signature of Witness
		Title/Relationship to Patient
Date	Print Name of Physician Witness	Signature of Physician Witness

Instead of oral consent, the HEALTH CARE AGENT or SURROGATE may choose to consent in writing to the DNR ORDER by executing the Consent Form attached to this Documentation Sheet. A WITNESS must sign this form. [In the case of a NON-HOSPITAL DNR ORDER, written consent must be on the form developed by the State attached to this Documentation Sheet.]

Step Seven

The RESPONSIBLE PHYSICIAN must promptly do one of the following:

a. issue the DNR ORDER; or
b. object to issuing the DNR ORDER and either transfer the patient to another RESPONSIBLE PHYSICIAN or refer the matter to the DISPUTE MEDIATION SYSTEM.

Indicate action taken:

____ DNR ORDER issued
____ Patient transferred to another RESPONSIBLE PHYSICIAN
____ Referred to DISPUTE MEDIATION

REMINDER: The DNR ORDER must be reviewed every seven days, or sooner if there is an improvement in the patient's condition, and the review must be documented in the medical record. The patient's risk of injury from a discussion of CPR must also be reassessed by the RESPONSIBLE PHYSICIAN on a regular basis. [A NON-HOSPITAL DNR ORDER must be reviewed each time the RESPONSIBLE PHYSICIAN examines the patient (but need not be reviewed more than once every seven days) but at least every ninety days and the review must be documented in the medical record.]

CONSENT BY HEALTH CARE AGENT OR SURROGATE TO DNR ORDER

1. I hereby authorize Dr. ______________________________ to issue a DNR ORDER on the patient ______________________________. I understand this means that cardiopulmonary resuscitation will be withheld in the event his/her heart stops beating or he/she stops breathing, unless that occurs during a surgical procedure or during the recovery period after a surgical procedure.

2. Dr. ________________________ has explained to me the patient's diagnosis and prognosis, the range of available resuscitation measures, the reasonably foreseeable risks and benefits of cardiopulmonary resuscitation, and the consequences of an order not to resuscitate the patient.

3. I am making this decision based on: (check one)

   ____a. the patient's known wishes; or

   ____b. the patient's best interest, since the patient wishes are unknown and cannot be ascertained.

4. My relationship to the patient is as follows: (check one)

   ____a. Health Care Agent (attach appropriate documentation)

   ____b. person designated by the patient to consent to DNR ORDERS prior to January 1, 1992 (attach appropriate documentation)

   ____c. court appointed committee or guardian (attach appropriate documentation)

   ____d. spouse

   ____e. son or daughter aged eighteen or older

   ____f. parent

   ____g. brother or sister aged eighteen or older

   ____h. close friend (attach "Friend's Affidavit")

5. To the best of my knowledge there is no one higher on the list in Section 4 above available to consent on behalf of the patient.

6. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

________________	______________________________	______________________________
Date	Print Name	Signature
		______________________________
		Title/Relationship to Patient

AFFIDAVIT OF CLOSE FRIEND

_____________________________, being duly sworn, deposes
(Name of Friend)

and says:

1. I reside at ____.

2. I am a close friend of the patient ___________________________ and have maintained such regular contact with the patient as to be familiar with his/her activities, health and religious or moral beliefs.

3. I base my statement that I am a close friend on the following facts and circumstances (describe relationship with patient, frequency of contacts, etc.):

____

____

____

____

____

____

____

____
Signature

Sworn to before me this ______
day of ____________, 19___.

____
Notary Public

WITNESS CERTIFICATION

I hereby certify that the surrogate signed and dated this form in my presence.

Date	Print Name	Signature
		Title/Relationship to Patient