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

DNR DOCUMENTATION SHEET #5
ADULT PATIENT WITHOUT CAPACITY AND WITH A SURROGATE*

Directions: This Documentation Sheet sets forth in consecutive order the steps that must be taken prior to writing a DNR Order [or NON-HOSPITAL DNR ORDER**] for an ADULT patient without CAPACITY who does not have a HEALTH CARE AGENT but who has a SURROGATE. Words that appear 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 lacks CAPACITY.

Determination of Capacity

I have examined the patient and have determined to a reasonable degree of medical certainty that he/she lacks the ability to understand and appreciate the nature and consequences of a DNR ORDER, including the benefits, disadvantages and alternatives, and to reach an informed decision. In my opinion, the cause and nature of the patient's incapacity are: ______________________________ ______________________________ and its extent and probable duration are: ______________________________.

Date	Print Name of RESPONSIBLE PHYSICIAN	Signature of RESPONSIBLE PHYSICIAN

Step Two

A CONCURRING PHYSICIAN*** must agree with the determination that the patient lacks CAPACITY.

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* If the patient has PREVIOUSLY CONSENTED to a DNR ORDER, use Documentation Sheet #3. If the patient has a HEALTH CARE AGENT, use Documentation Sheet #4.

** Under these circumstances, until September 1, 1992, a NON-HOSPITAL DNR ORDER may only be written during a patient's hospitalization, to take effect after hospitalization.

*** If the patient's incapacity is due to a DEVELOPMENTAL DISABILITY or MENTAL ILLNESS, the concurring opinion must be provided by a physician with specialized training. See DNR Policy, Section IIF.

CONCURRING PHYSICIAN's Statement

I have personally examined the patient and have determined to a reasonable degree of medical certainty that he/she lacks the ability to understand and appreciate the nature and consequences of a DNR ORDER, including the benefits, disadvantages and alternatives, to reach an informed decision. In my opinion, the cause and nature of the incapacity is: ______________________________
and its extent and probable duration are: ______________________________.

____________	____________	____________
Date	Print Name of CONCURRING PHYSICIAN	Signature of CONCURRING PHYSICIAN

Step Three

The RESPONSIBLE PHYSICIAN must determine the proper SURROGATE. The SURROGATE must be selected from the following list in the order of priority listed.

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

Name of Surrogate ______________________ Relationship to Patient ______________________ *

Step Four

The RESPONSIBLE PHYSICIAN must notify the SURROGATE of the determination that the patient lacks CAPACITY. In addition, if there is any indication of the patient's ability to understand, notice must be given to the patient, together with a copy of the Department of Health's DNR Statement of Rights.

Notice to Patient and Surrogate of Lack of Capacity

(a) I have provided notice of the determination of the patient's lack of capacity to the surrogate; and
(b) (check one):

______ 1. There is no indication of the patient's ability to comprehend such notice and I am therefore not providing notice to the patient; or

______ 2. I have given the patient notice of determination.

____________	____________	____________
Date	Print Name of RESPONSIBLE PHYSICIAN	Signature of RESPONSIBLE PHYSICIAN

* If there is no qualified SURROGATE, you must use Documentation Sheet #6.

Step Five

The RESPONSIBLE PHYSICIAN must determine that the patient is suitable for the issuance of a DNR ORDER. A CONCURRING PHYSICIAN must agree with the determination.

Determination of Suitability for DNR Order

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

_____a. the patient has a terminal condition; or
_____b. the patient is permanently unconscious; or
_____c. resuscitation would be medically futile; or
_____d. 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 Six

The 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 event of a NON-HOSPITAL DNR ORDER, the physician WITNESS must be the RESPONSIBLE PHYSICIAN.]

Witness' Statement (Oral Consent)

The surrogate has expressed orally in my presence the decision to consent to a DNR order, subject to the following criteria or conditions (if any):

1. Consent not applicable during a surgical procedure 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

Alternatively:

Instead of oral consent, the SURROGATE may choose to consent in writing to the DNR ORDER by executing the Consent Form attached to the end of 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 of New York attached to this Documentation Sheet.]

Step Seven

If there is any indication of the patient's ability to comprehend, and the RESPONSIBLE PHYSICIAN has not determined that the patient would suffer immediate and severe injury from a discussion of CPR, notice of the SURROGATE's decision must be provided to the patient.

Notice to Patient of DNR Order

Check One:

_____ a. I have determined that the patient has not given any indication of ability to comprehend, and I am not therefore providing notice of the surrogate's decision to the patient; or

_____ b. I have determined that patient would suffer immediate and severe injury from a discussion of CPR, and I am not therefore providing notice of the surrogate's decision to the patient; or

_____ c. Neither a. nor b. apply and I have provided notice of the surrogate's decision to the patient.

Date	Print Name of RESPONSIBLE PHYSICIAN	Signature of RESPONSIBLE PHYSICIAN

IF THE PATIENT OBJECTS, A DNR ORDER MUST NOT BE WRITTEN

Step Eight

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: (check one)

_______ DNR Order issued
_______ Patient transferred to another RESPONSIBLE PHYSICIAN
_______ Referred to DISPUTE MEDIATION

Consent By 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 interests, since the patient's wishes are unknown and cannot be ascertained.

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

    _____a. person designated by the patient to make decisions about DNR ORDERS prior to January 1, 1992 (attach appropriate documentation)

    _____b. Court appointed committee or guardian (attach appropriate documentation)

    _____c. spouse

    _____d. son or daughter aged eighteen or older

    _____e. parent

    _____f. brother or sister aged eighteen or older

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

5. To the best of my knowledge the patient has not appointed a health care agent and 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 of SURROGATE	Signature of SURROGATE

REMINDER: The DNR ORDER must be reviewed every seven days, or sooner if there is an improvement in the patient's condition, or for alternate level of care patients, each time the patient is examined by a physician but at least every sixty days, and the review must be documented in the medical record. [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.]

WITNESS CERTIFICATION

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

____________	______________________	______________________
Date	Print Name	Signature
		______________________
		Title/Relationship to Patient

AFFIDAVIT OF CLOSE FRIEND

______________________being duly sworn, deposes and
(Name of Friend)

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