REVIEW OF DO NOT RESUSCITATE (DNR) ORDERS

Region/TS: NR SR WR STS

Regional Director Notified:   /  /     Director of Health Services Notified:   /  /

***If any box is checked as NO or UNCERTAIN,***

***the Director Of Health & Clinical Services and the Commissioner MUST BE NOTIFIED.***

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| Name: |  | Date of Birth: | | /  / | DDS #: |  |
| Address: |  | Agency: |  | | | |

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| Has the person been adjudicated incompetent? | | Yes (\* If “No” please see comment section below) | | | |
| *If yes, name of person’s guardian:* |  | | | | |
| Has the decision to place the DNR order been fully discussed with the person, family and/or guardian? | | | | | Yes No |
| *Explain:* | | | | | |
| Is the person terminally ill (i.e., final state of an incurable or irreversible medical condition)? | | | | Yes No Uncertain | |
| *Explain:* | | | | | |
| Is the person expected to die within days or weeks? | | | Yes  No  Uncertain | | |

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| TREATMENT | | | | | |
| Describe current treatment: | | | | | |
| Primary Physician/APRN: |  | | Specialty: |  | |
| Physician/APRN providing second opinion: | |  | Specialty: |  | |
| Is the specialty of at least one physician/APRN appropriate to the terminal/irreversible diagnosis? | | | | | Yes No |
| Do both physicians/APRN concur that the person is in the final stages of a terminal/irreversible condition? | | | | | Yes No |

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| REQUEST/ORDER | | | |
| Person requesting DNR Order: |  | Relationship to person: |  |
| Date DNR Order Reviewed: | /  / | | |
| *Comments:* | | | |

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| --- | --- | --- | --- |
| Signature Regional Health Services/STS Medical Director: |  | Date: | /  / |
| Signature Regional/STS Director: |  | Date: | /  / |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Central Office Director of Health & Clinical Services Notified: | | Date:   /  / | | |
| Signature Central Office Health & Clinical Services Director: |  | | Date: | /  / |
| *\* Comments:*  *This meets DDS DNR criteria in accordance with section 17a-238(g) CGS*  *This person is exempt from the DDS DNR process due to not being adjudicated or having advanced*  *directives or a living will in place*  *Additional Information:* | | | | |

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| Signature Commissioner: |  | Date: | /  / |
| *Comments:* | | | |

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| Director of Legal & Governmental Affairs Notified: | /  / | By: |  |

Distribution: Original: Regional Health Services Director

Copies: Case Manager/QIDP, Private Agency Executive Director