

Mount Sinai Health System New York, NY

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DNR/LST/FHCDA Form 4

continuing incapacity must be made. See Step VII.

Adult Patient: Surrogate Consent to Withhold or Withdraw Life-Sustaining Treatment, Including DNR (See clinical criteria on page 4 of this form)

	9	, 9	•	,
This fo	orm must be filled out with	the approval of the Primary Attend	ling Physician ² .	of primary attending
	DT use this form if the pati d, use Form 2.	ent has appointed a health care p	roxy and the agent is av	ailable.
	OT use this form for a pation d, contact the Office of the	ent who lacks capacity due to me e General Counsel.	ntal illnes or developme	ntal disability.
		ncapacity (SKIP AND PROCEED on make health care decisions).	TO STEP II if a court has al	ready determined
	•	ding Physician, other attending physicia the determination of incapacity as long		
а. [Determination of Incapacity	1		
- 1	have determined to a reaso	nable degree of medical certainty tha	at the patient lacks capacit	ty to make the
C	decision described as follow	'S:		
I	found that the cause and ex	tent of the patient's incapacity are _		
a	and the likelihood that the pa	tient will regain decision-making cap	pacity is	·
Clini	cian³ (print name)	Signature	Date	Time
b. (Concurring Determination of	of Incapacity		
- 1	independently concur to a r	easonable degree of medical certair	nty that the patient lacks ca	apacity to make the
c	decision. I found that the cau	se and extent of the pateint's incapa	city are	
a	and the likelihood that the pa	utient will regain decision-making cap	pacity is	
Clini	cian³ (print name)	Signature	 Date	Time
NO	OTF: For all treatments not pro	vided at or about the time of the initial det	ermination of incapacity a co	onfirmation of

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¹ "Life-sustaining treatment" means any medical treatment or procedure without which the patient will die in a relatively short time, as determined by the Primary Attending Physician to a reasonable degree of medical certainty.

² The Primary Attending Physician is an attending physician who is a member of the Mount Sinai Medical Staff and is directing the patient's care at the time the relevant determination or decision is being made and may also include a covering attending physician directing the patient's care when the Primary Attending Physician is unavailable.

³ The Primary Attending Physician and with the Primary Attending Physician's approval, another physician, nurse practitioner, physician's assistant or licensed house staff.

II. Patient's Prior Decision to Withhold or Withdraw

a. No Prior Decision

b.

Prior decisions are specific well-settled decisions which may have been included in the following documents: a MOLST form, health care proxy forms, living wills etc.

	To the best of my knowledge, the withdrawing life-sustaining treat		=	nholding or
Pri	ior Decision (All prior decisions r	nust be recorded in the medica	al record.)	
1.	Substance and Form of Prior D	ecision		
	a. For prior decisions to withhous previously made the following	old or withdraw life sustaining ng decision(s) (Check as appli	·	२, the patient
	☐ Consent to a DNR order (a	allow for natural death)		
	(i.e. intubation*, pressors,	thdraw the following other life s antibiotics, dialysis, and artificia ied to be withdrawn, it is assum	al nutrition and hydration)	ation in the setting
	b. Form of Decision: (Check on	e. May be oral, if witnessed, or	may be written)	
	The patient made the prior decis	sion in the following manner:		
		n the presence of the two witn r, at least one of whom is a hea		
Wit	tness 1 ⁴ (print name)	Signature	Date	Time
Wit	tness 2 ⁴ (print name)	Signature		Time
	OR In writing (a MOLST, living will c. Attestation of Clinical Circuit			
	☐ The patient stated that their of the following specific clinical		w treatment would become	e effective under
	I have determined that such circ	umstances are now present, ar	nd the consent is now effe	ctive.
Clir	nician³ (print name)	Signature	Date	Time

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 $^{^{\}rm 4}\,$ Witness must be 18 years of age or older.

-	e)				
 A Surrogate has been identifing the decomplementing the decomplement. 		ee Section III below), and I ha	ave notified	the Surrogate
 A Surrogate has been identifined despite the following diligent 		ut was NOT notified	prior to i	mplementi	ng the decision
Clinician ³ (print name)	 Signature		Date		Time
Preferred Language Interpreter Name or Number	Signature		Date	Time	Surrogate refused interpreter (check box if applicable)
Telephone/Video Consent (Check box if a	applicable), Patient/G	uardian/Representa	tive**/Int	erpreter sig	nature not required.
III. Identify and Inform the Surro a. Identifying the Surrogate	gate				
The Surrogate is the highest perso to act: (Check one and identify bel	_	list who is reasona	bly availa	ble, willing,	, and competent
$\ \square$ A guardian authorized to decide	e about health care p	oursuant to Mental I	Hygiene I	_aw Article	81
☐ The spouse, if not legally separa	ated from the patien	t, or the Domestic F	artner⁵		
☐ A son or daughter eighteen yea					
- Asonor daugnter eighteen yee	ars of age or older				
☐ A parent	ars of age or older				
☐ A parent					
□ A parent□ A brother or sister eighteen year		Relationship to Patie	nt		
 □ A parent □ A brother or sister eighteen yea □ A Close Friend⁶ Name of Surrogate 		Relationship to Patie Email address	nt		
 □ A parent □ A brother or sister eighteen yea □ A Close Friend⁶ Name of Surrogate 	ars of age or older	_	nt		
☐ A parent ☐ A brother or sister eighteen yea ☐ A Close Friend ⁶ Name of Surrogate Home phone number Mobile	ars of age or older phone number t the patient has bee	Email address n determined to lac	k capaci	ry and that	the Surrogate, if
☐ A parent ☐ A brother or sister eighteen year ☐ A Close Friend ⁶ Name of Surrogate Home phone number Mobile b. Informing the Surrogate I have informed the Surrogate that	ars of age or older phone number t the patient has bee	Email address n determined to lac	k capaci	y and that	the Surrogate, if

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 $^{^5\,}$ If the Surrogate is a Domestic Partner, use FHCDA Form 2 to document their status. $^6\,$ If the Surrogate is a Close Friend, use FHCDA Form 2 to document their status.

uec	patient has been informed of ision(s) for them; OR	the determination of incapa	city, the choice of Sur	rogate and	d the health care
	patient has NOT been informore patient has NOT been information.	ed of the above because the	ere is no indication the	at the patie	nt can
Clinician³ (print n	name)	Signature	Date		Time
Preferred Langu	age Interpreter Name or Number	Signature		Time	Patient refused interpreter (check box if applicable)
Telephone	e/Video Consent (Check box if	applicable), Patient/Guardian	/Representative**/Int	erpreter sig	.,
	E: If the patient objects to the onthe ont		_		
	cal Criteria for Withhold		•	eatment	
Two assis	cian Opinion on Clinical Crite Clinicians (the Primary Attend stants, or licensed house staff) nding Physician concurs.	ling Physician, other attendir	ng physicians, nurse p		
	Criteria A				
	1. I have determined, to a re	easonable degree of medica	I certainty that:		
		ess or injury which can be ex	-	th within si	x months,
	☐ the patient has an illne	ess or injury which can be ex nent is provided; OR	-	th within siz	x months,
	□ the patient has an illne whether or not treatm□ the patient is permane	ess or injury which can be ex nent is provided; OR ently unconscious;	pected to cause dea		
	the patient has an illne whether or not treatmthe patient is permaneAND	ess or injury which can be ex nent is provided; OR ently unconscious;	pected to cause dea		
	 □ the patient has an illne whether or not treatm □ the patient is permane AND 2. It has been determined the 	ess or injury which can be expent is provided; OR ently unconscious; hat treatment would be an expense asonable degree of medical	xpected to cause dea	o the patier	nt.
	 □ the patient has an illne whether or not treatm □ the patient is permane AND 2. It has been determined the Criteria B 1. I have determined, to a reincurable condition; AND 2. It has been determined the 	ess or injury which can be expent is provided; OR ently unconscious; hat treatment would be an expension and the expension of the expension	expected to cause deal	o the patie tient has ar pain, suffer	nt. n irreversible or ring or other
	 □ the patient has an illnewhether or not treatm □ the patient is permane AND 2. It has been determined the incurable condition; AND 2. It has been determined, to a reincurable condition; AND 2. It has been determined the burden that it would reas 	ess or injury which can be expent is provided; OR ently unconscious; hat treatment would be an expensionable degree of medical that the provision of treatment	expected to cause deal	o the patie tient has ar pain, suffer	nt. n irreversible or ring or other

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⁷ If the patient was transferred from a mental hygiene facility, notice must also be given to the director of the facility and to Mental Hygiene Legal Services.

Clinician ³ (pri	nt name)	Signature	Date	Time			
_	ate's Consent to Wit ad Witness Confirm	thhold or Withdraw Life- ation	Sustaining Treatment	, including			
a. Extent	of Decision(s) (Check a	as applicable)					
□ Cor	□ Consent to a DNR order						
□ Cor	Consent to with hold or withdraw the following other life-sustaining treatment:						
b. Form o	of Surrogate Decision (C	Can be oral OR written)					
	orm of Surrogate Decision (Can be oral OR written) Written Decision						
to c crite pati	onsult with such other he	pportunity to ask questions and ealth care professionals and othing as the Primary Attending Physision-making capacity. Signature	er persons as I wish to cons	ult that the clinical			
2 Ora	l Decision						
The	The Surrogate expressed the decision described above, as well as the basis of the decision as described above, orally to me.						
nician³ (print nam	e)	Signature	Date	Time			
eferred Language	Interpreter Name or Number	Signature	Date Time	Surrogate refuse interpreter (check box if applicable)			
_		if applicable), Patient/Guardian/	Representative**/Interpreter	signature not required.			
	s to the Surrogate's Dec vitnessed the Surrogate :	cision s written or oral decision to with	hold or withdraw life-sustair	ning treatment			
i i iavo v		2ttorr or oral doolololl to With					

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VII. Confirming Determination of Continued Incapacity

Clinician³ (print name)	Signature	Date	Time
I have confirmed that the patient continue	s to lack decision-making capacity.		
incapacity, ongoing confirmation of contir	nued incapacity is required.		
For all subsequent health care decisions t	hat are not made at or about the time of	of the determination	n of

VIII. Ethics Process

Should an ethics consultation be helpful, please contact the system operator at 212-241-6500 (See hospital's Ethics Committee policy).

IX. Clinician's Order

The Clinician **shall enter** the order to withhold or withdraw treatment in the medical record consistent with the Surrogate's decision **as long as the Primary Attending Physician concurs.**

THIS FORM MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.

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⁸ Review by the Ethics Review Committee is required and the ERC's decision is binding when: the clinican objects to a Surrogate's decision to withhold or withdraw artificial nutrition or hydration for an adult patient who is not terminally ill or permanently unconscious; OR an emancipated minor makes a decision to withhold or withdraw life sustaining treatment.