

Mount Sinai Health System New York, NY

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# **DNR/LST/FHCDA Form 5**

Adult Patient Without a Surrogate: Authorization to Withhold or Withdraw Life-Sustaining Treatment<sup>1</sup> including DNR (See clinical criteria on page 5 of this form)

his form must be filled out wit	h the approval of the Primary Atter	nding Physician².	of primary attending			
O NOT use this form if the pa	tient has appointed a health care	proxy and the agent is a	vailable.			
ONOT use this form if a Surr	ogate is identified. Instead use Fo	orm 4.				
ONOT use this form for a panstead, contact the Office of	tient who lacks capacity due to m the General Counsel.	ental illness or developm	nental disability.			
that the patient lacks capacity	Incapacity (SKIP AND PROCEED to make health care decisions).		•			
- · · · · · · · · · · · · · · · · · · ·	ending Physician, other physicians, nu termination of incapacity <b>as long as th</b>					
a. Determination of Incapacity						
I have determined to a reasonable degree of medical certainty that the patient lacks capacity to make the						
decision as follows:						
I found that the cause and e	extent of the patient's incapacity are					
and the likelihood that the p	oatient will regain decision-making ca	apacity is				
Clinican³ (print name)	Signature		Time			
b. Concurring Determination	of Incapacity					
I have determined to a reas	onable degree of medical certainty t	that the patient lacks capac	ity to make the			
decision as follows:			·			
I found that the cause and	extent of the patient's incapacity are					
and the likelihood that the p	oatient will regain decision-making ca	apacity is	·			
Clinician³ (print name)	Signature	Date	Time			
NOTE: For all treatments not proincapacity must be made. See S	vided at or about the time of the initial de	etermination of incapacity, con	firmation of continuing			

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<sup>&</sup>lt;sup>1</sup> "Life-sustaining treatment" means any medical treatment or procedure without which the patient will die in a relatively short time, as determined by the Clinician to a reasonable degree of medical certainty. Cardio pulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a determination by an attending physician.

<sup>&</sup>lt;sup>2</sup> 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.

<sup>&</sup>lt;sup>3</sup> 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

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

a.	No	Prior Decision					
		To the best of my knowledge, the pa withdrawing life-sustaining treatme		vith regard to withh	olding or		
b.	Pr	ior Decision (All prior decisions must	be recorded in the medical record.)	)			
	1.	1. Substance and Form of Prior Decision					
		a. For prior decisions to withhold or previously made the following dec		including DNR, the	patient		
<ul> <li>□ Consent to withhold or withdraw the following other life sustaining treatment(s):         (i.e. intubation*, pressors, antibiotics, dialysis, and artificial nutrition and hydration)         *If intubation is not specified to be withdrawn, it is assumed the patient wants intubation in the of respiratory arrest.</li> <li>2. Form of Decision: (Check one. May be oral, if witnessed, or may be written)</li> </ul>							
Orally during hospitalization in the presence of the two witnesses listed below, both of whom are eighteen years of age or older, at least one of whom is a health or social services practitioner affi with the hospital.							
	Wi	tness 1 <sup>4</sup> (print name)	Signature	Date	Time		
	Wi	tness 2 <sup>4</sup> (print name)	Signature	Date	Time		
		OR					
		☐ In writing (e.g., a living will, MOLS)	Γ, health care proxy etc.).				
	3.	Attestation of Clinical Circumstanc					
☐ The patient stated that his or her consent to withhold or withdraw treatment would become effective under the following specific clinical circumstances:							
Tha	ave	e determined that such circumstances	are now present, and the consent	is now effective.			
Clin	nicia	an <sup>3</sup> (print name)	Signature	Date	Time		

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

# **III. Document Lack of Surrogate**

Clinician <sup>3</sup> (print name)	Signature	Date	Time
Notify the Patient <sup>5</sup> (Check one)			
☐ The patient has been informed that he	or she has been determi	ned to lack capacity; <b>OR</b>	
comprehend the information.			
Clinician³ (print name)	Signature	Date	Time
Clinician³ (print name)	Signature	Date	Patient refus
Clinician³ (print name)  Preferred Language Interpreter Name or Number	Signature Signature	Date  Date  Time	Time  Patient refus interpreter (check box if applicable)

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<sup>&</sup>lt;sup>5</sup> 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.

# V. Clinical Criteria for Withholding or Withdrawing Life-Sustaining Treatment

a. Primary Attending Physician Opinion on Clinical Criteria (Check whether Criteria A or B applies).

Two Clinicians (the Primary Attending Physician, other physicians, nurse practitioners, physician assistants, or licensed House Staff) must make the determination of incapacity as long as the Primary Attending Physician concurs.

	Criteria A					
	1. I have determined, to a	a reasonable degree of medical c	sonable degree of medical certainty that:			
the patient has an illness or injury which can be expected to cause dea whether or not treatment is provided; OR				n six months,		
	□ the patient is perma	anently unconscious;				
	AND  2. It has been determined that treatment would be an extraordinary burden to the patient.					
	Criteria B					
	<ol> <li>I have determined, to a reasonable degree of medical certainty that the patient has an irreversi incurable condition; AND</li> </ol>					
<ol> <li>It has been determined that the provision of treatment would involve such pain, suffering of burden that it would reasonably be deemed inhumane or extraordinarily burdensome und circumstances.</li> </ol>						
Clinician <sup>3</sup>	³ (print name)	Signature	Date	Time		
		•				
b. Con	curring Clinician's Opinion	on Clinical Criteria:				
Thav	re made an independent med	dical determination and concur w	ith the Clinician's clinical de	etermination above.		
Clinician <sup>3</sup>	3 (print name)	 Signature		Time		

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# **VI. Confirming Determination of Continued Incapacity**

ongoing confirmation of continued in I have confirmed that the patient cor		capacity.	
Clinician <sup>3</sup> (print name)	Signature	 Date	Time

#### **VII. Ethics Process**

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

#### VIII. Clinician's 3 Order

The Clinician shall enter the order to withhold or withdraw treatment, including DNR in the medical record as long as the Primary Attending Physician concurs.

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

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