Mount Sinai

Mount Sinai Health System
New York, NY

DNR/LST Form 2

Patient Without Capacity who has a Designated Health Care Agent/Proxy: Consent to Withhold and/or Withdraw Life-Sustaining Treatment[1], Including CPR

This form must be filled out with the approval of the Primary Attending Physician[2]. _____
Print name of primary attending

DO NOT use this form if the patient has not appointed a health care proxy. Instead, use DNR/LST Form 4 or 5, also known as FHCDA Form 4 or 5.

DO NOT use this form for a patient who lacks capacity due to mental illness or developmental disability. Instead, please contact the Office of General Counsel.

I. Initial Determination of Incapacity (SKIP AND PROCEED TO STEP II if a court has already determined that the patient lacks capacity to make health care decisions).

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.**

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 extent of the patient's incapacity are _____

and the likelihood that the patient will regain decision-making capacity is _____.

Clinican[3] (print name)	Signature	Date	Time

b. Concurring 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 extent of the patient's incapacity are _____

and the likelihood that the patient will regain decision-making capacity is _____.

Clinician[3] (print name)	Signature	Date	Time

[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 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.

[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.

NOTE: If the patient objects to the determination of incapacity or health care decision, the patient's wishes prevail unless there is a medical emergency or a court order (See FHCDA Policy [MSHS 206]).

1. Identify the Agent

The Agent is a person who has been designated on a properly executed health care proxy form, a copy of which should be made part of the patient's medical record. The agent must be 18 years of age or older and reasonably available, willing and competent to act.

Name of Agent	Relationship to Patient	Date	Time

2. Notice to Agent

I have informed the Agent that the patient has been determined to lack capacity and that the Agent will make health care decisions for the patient.

Clinician[3] (print name)	Signature	Date	Time

Preferred Language Interpreter Name or Number	Signature	Date	Time	
				☐ Patient refused interpreter *(check box if applicable)*

☐ **Telephone/Video Consent (Check box if applicable), Patient/Guardian/Representative**/Interpreter signature not required.**

3. Notify the Patient

☐ The patient has been informed that he or she has been determined to lack capacity; **OR**

☐ The patient has NOT been informed of the above because there is no indication that the patient can comprehend the information.

Clinician[3] (print name)	Signature	Date	Time

Preferred Language Interpreter Name or Number	Signature	Date	Time	
				☐ Patient refused interpreter *(check box if applicable)*

☐ **Telephone/Video Consent (Check box if applicable), Patient/Guardian/Representative**/Interpreter signature not required.**

[4] The patient's written consent must be dated and signed in the presence of a witness who must also date and sign the form.

[5] The patient's oral consent must also be dated and signed in the presence of two witnesses who must also sign the form, one of whom must be an attending physician and the other must be on staff at the hospital.

[6] Witness must be 18 years of age or older.

II. Reconfirmation of Incapacity

I reconfirm that the patient continues to lack capacity.

(Required if the initial determination of incapacity was made more than 24 hours before the Agent makes a health care decision on behalf of the patient.)

Clinician[3] (print name)	Signature	Date	Time

III. Agent's Consent to Withhold or Withdraw Life-Sustaining Treatment, Including CPR

1. Informed Consent Discussion

The Agent has been provided information about his/her diagnosis and prognosis, life- sustaining treatment options, including cardiopulmonary resuscitation measures ("CPR") and a DNR order, the reasonably foreseeable risks and benefits of these treatment options for him/her, and the consequences of withholding or withdrawing life-sustaining treatment, including CPR.

Clinician[3] (print name)	Signature	Date	Time

2. Agent's Consent

I make this decision(s):

☐ Consent to a DNR order with the following restrictions (if any). If none, write, "None"

_____

☐ Consent to withhold or withdraw other life-sustaining treatment(s):

_____

3. Agent's Written Consent

a. I have discussed this decision with the Attending Physician and/or appropriate clinician who has informed me of the patient's diagnosis and prognosis and who has explained to me the risks, benefits and alternatives to this decision. I have had an opportunity to ask questions and to have them answered to my satisfaction, and to consult with such other health care professionals and other persons as I wish to consult.

b. I am making this decision in accordance with the patient's wishes, including their religious and moral beliefs; or I do not know and cannot with reasonable diligence determine the patient's wishes and therefore I am making this decision in accordance with the patient's best interests.

Agent Name	Signature	Date	Time

Witness[4]	Signature	Date	Time

[4] Witness must be 18 years of age or older.

3. Agent's Oral Consent

If the Agent expresses their decision orally to the attending physician and/or another appropriate clinician, the Agent's consent must be documented below:

The Agent expressed the decision indicated above as well as the basis for the decision as described above, orally in the presence of myself and one other witness.

Clinician[3] (print name)	Signature	Date	Time

Preferred Language Interpreter Name or Number	Signature	Date	Time	☐ Patient refused interpreter *(check box if applicable)*

☐ **Telephone/Video Consent (Check box if applicable), Patient/Guardian/Representative**/Interpreter signature not required.**

IV. Witness to Patient's Consent (written or oral)

I have witnessed the Agent's written or oral decision to withhold or withdraw life- sustaining treatment, including CPR.

Witness 1[4] (print name)	Signature	Date	Time

Witness 2[4] (print name)	Signature	Date	Time

V. Ethics Process

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

VI. Documentation

The Clinican must document in the medical record the treatment(s) to be withheld or withdrawn and issue the appropriate medical order(s) at such time as any conditions specified by the agent are met **as long as the Primary Attending Physician concurs**.

REMINDER: Any order to withhold or withdraw life-sustaining treatment must be reviewed on a regular basis and no less than every seven days. If there is a change in the patient's condition there should be a determination as to whether the order is still appropriate.

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