

VERMONT DNR/COLST - Clinician orders for DNR/CPR & Other Life Sustaining Treatment

PATIENT: _____ BIRTHDATE: _____
 LAST NAME FIRST NAME MIDDLE INITIAL

SECTION A: Cardiopulmonary Resuscitation: Follow these orders when the patient is unresponsive, has no pulse

- NO CPR: Do Not Attempt Resuscitation (DNR)**
 (Allow Natural Death)
- YES CPR: Attempt Resuscitation**, including intubation, mechanical ventilation, defibrillation and transfer to hospital.

Basis for DNR order: informed consent OR medical non-benefit (Choose one)

Informed Consent obtained from:

 Name of Person Giving Informed Consent (Can be Patient)

 Relationship to Patient (Write "self" if Patient)
 (agent, guardian or surrogate)

 Signature (if available)
 Verbal Consent

OR

This DNR order is written on the basis of medical non-benefit (futility). Required if no consent.

I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined:

 Name of Other Clinician Making this Determination (Print here)

 Signature of Other Clinician Date

SECTION B: Intubation and Ventilation: Follow these orders in the event of respiratory distress, has a pulse

Instructions for Intubation and Ventilation: (Invasive: place a tube down the patients throat and connect a breathing machine)

- Mark one circle → NO, do not intubate and ventilate (DO NOT check if you checked "attempt CPR" in section A)
- TRIAL COURSE, of intubation and ventilation treatment
- YES, intubate and ventilate

SECTION C: Medical Intervention Guidelines

- Focus on Sustaining Life.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. *Transfer to hospital and/or intensive care unit if indicated.* All patients will receive comfort-focused treatments.
Treatment Plan: Full treatment including life support measures in the intensive care unit.
- Avoid Invasive Interventions.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. high flow, CPAP, BiPAP). *Transfer to hospital if indicated.* Generally avoid intensive level of care (e.g. ICU). All patients will receive comfort-focused treatments.
Treatment Plan: Provide basic medical treatments aimed at treating new or reversible illness.
- Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care, and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers *no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Maximize comfort through symptom management.

Facility DNR Protocol Requirement (required for patients in health care or residential care facilities)

This patient is is not in a health care facility or a residential care facility.

Name of Facility: _____

The requirements of the facility's DNR protocol have been met. _____ (Initial here if protocol requirements have been met.)

SIGNATURE OF CLINICIAN for section A, B & C

Authorization of DNR Identification

Clinician (Print Name): _____ Signature: _____ Date _____

SECTION D: Orders For Other Life Sustaining Treatments

Artificially Administered Nutrition and Hydration

Nutrition Mark one circle → <input type="radio"/> NO, do not administer artificial nutrition	<input type="radio"/> TRIAL COURSE, of short-term artificial nutrition. No long term.	<input type="radio"/> YES, administer artificial nutrition	<input type="radio"/> Did not discuss
Hydration Mark one circle → <input type="radio"/> NO, do not administer artificial hydration	<input type="radio"/> TRIAL COURSE, of short-term artificial hydration	<input type="radio"/> YES, administer artificial hydration	<input type="radio"/> Did not discuss
Antibiotics Mark one circle → <input type="radio"/> NO, do not use antibiotics	<input type="radio"/> Determine use or limitation of antibiotics when infection occurs, with comfort as goal.	<input type="radio"/> YES, administer antibiotics (if indicated)	<input type="radio"/> Did not discuss

Other preferences (e.g. dying at home, awareness/level of consciousness, living independently, etc.) and treatment goals specific to the patient's medical condition and care needs (e.g. blood products, dialysis, etc.).

Informed Consent for orders for other life sustaining treatment (section D) has been obtained from:

 Name of Person Giving Informed Consent (Can be Patient) Relationship to Patient (Write "self" if Patient) Signature (if available)

Verbal Consent

SIGNATURE OF CLINICIAN for section D

Clinician Signature: _____ Date _____

SECTION E: Other Medical Decision-Making Information (Check all that apply)

Health Care Agent/Advance Directive Guardianship Order Surrogate

 Name of Health Care Agent(s) / phone Name of Guardian / phone# Name of Surrogate / phone#

Note: This section CANNOT be used to appoint the health care agent or guardian. Only check if there is existing documentation of medical decision-makers in an advance directive or court order for guardianship.

SECTION F: REVIEWS

Date	Reviewer	Location	Outcome
			<input type="radio"/> No Change <input type="radio"/> New form completed <input type="radio"/> Form Voided

Instructions For Clinicians Completing This Form

Completing DNR/COLST: <ul style="list-style-type: none"> Must be completed and signed by a health care clinician (MD, DO, APRN, or PA) based on patient's medical condition, goals and values. Verbal orders are acceptable with follow-up signature by the clinician in accordance with facility/agency policy. Photocopies and faxes of signed DNR/COLST order are legal and valid. By signing, clinician is certifying that they have consulted or made an attempt to consult with the patient, the patient's agent, guardian or surrogate. 	Documenting Clinician's Verbal Order <ul style="list-style-type: none"> The patient's nurse or social worker must print the clinician's name and write "Verbal Order" on the clinician signature line. The nurse or social worker documenting the verbal order must also sign and date the form. A duplicate DNR/COLST must be completed and sent to the clinician for an original signature. At the earliest convenience, the order with the original signature must be returned to the patient to replace the previously documented verbal order.
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