Illinois Department of Public Health

# UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

## PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

**HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT**

Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition, new orders may need to be written.

See also Guidance for Health Care Professionals at http://www.idph.state.il.us/public/books/advin.htm.

| Patient Last Name | Patient First Name | MI |
|---|---|---|
| Date of Birth (mm/dd/yy) | Gender ❑ M ❑ F | |
| Address (street/city/state/ZIPcode) | | |

**A** Check One

**CARDIOPULMONARY RESUSCITATION (CPR) Patient has no pulse *and* is not breathing.**

- ❑ **Attempt Resuscitation/CPR** (*Selecting CPR means* **Intubation and Mechanical Ventilation** *in Section* **B** *is selected*)
- ❑ **Do Not Attempt Resuscitation/DNR**

***When not in cardiopulmonary arrest, follow orders B and C.***

**B** Check One

**MEDICAL INTERVENTIONS Patient has pulse and/or is breathing.**

- ❑ **Comfort Measures Only** (Allow Natural Death). Relieve pain and suffering through the use of medication by appropriate 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.**
- ❑ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.* **Treatment Plan: Provide basic medical treatments.**
- ❑ **Intubation and Mechanical Ventilation** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.* **Treatment Plan: Life support measures, including intubation, in the intensive care unit.**
- ❑ **Additional Orders** _____

**C** Check One *(optional)*

**ARTIFICIALLY ADMINISTERED NUTRITION Offer food by mouth, if feasible and as desired.**

- ❑ No artificial nutrition by tube.
- ❑ Defined trial period of artificial nutrition by tube.
- ❑ Long-term artificial nutrition by tube.

**Additional Instructions (e.g., length of trial period)**

_____

_____

**D**

**DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)**

- ❑ Patient
- ❑ Parent of minor
- ❑ Agent under health care power of attorney
- ❑ Health care surrogate decision maker (See Page 2 for priority list)

**Signature of Patient or Legal Representative**

| Signature *(required)* | Name (print) | Date |
|---|---|---|
| | | |

**Signature of Witness to Consent** (Witness required for a valid form)
I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

| Signature *(required)* | Name (print) | Date |
|---|---|---|
| | | |

**E**

**SIGNATURE OF ATTENDING PHYSICIAN**

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

| Print Attending Physician Name *(required)* | Phone ( ) _____ - _____ |
|---|---|
| Attending Physician Signature *(required)* | Date *(required)* |



SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

****THIS SIDE FOR INFORMATIONAL PURPOSES ONLY****

| Patient Last Name | Patient First Name | MI |
|---|---|---|
| | | |

The Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive is **always voluntary** and is for persons with advanced or serious illness or frailty. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

**Advance Directive Information**

**I also have the following advance directives (OPTIONAL)**

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

| Contact Person Name | Contact Phone Number |
|---|---|
| | |

**Health Care Professional Information**

| Preparer Name | Phone Number |
|---|---|
| | |
| **Preparer Title** | **Date Prepared** |
| | |

## Completing the IDPH Uniform Do Not Resuscitate (DNR) Advance Directive Form

- **The completion of a DNR form is always voluntary, cannot be mandated and may be changed at any time.**
- A DNR form should reflect current preferences of persons with advanced or serious illness or frailty. Also, encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

### Reviewing a Do Not Resuscitate (DNR) Advance Directive Form

This DNR form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another,
- or there is a substantial change in the patient's health status,
- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

### Voiding or revoking a Do Not Resuscitate (DNR) Advance Directive Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR form requires completion of a new DNR form.
- Draw line through sections A through E and write "VOID" in large letters if any DNR form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

### Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://www.idph.state.il.us/public/books/advin.htm

**HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT**



**SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**

UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■