TO:

FROM:

DATE:

SUBJECT: **DNR REQUEST FORM GUIDELINES**

**ATTACHED IS THE KENTUCKY CABINET FOR FAMILIES & CHILDREN DNR REQUEST FORM. PLEASE FOLLOW THESE GUIDELINES**

I PERTINENT SECTIONS ARE TO BE COMPLETED. INCOMPLETE FORMS CANNOT BE CONSIDERED AND WILL DELAY THE PROCESS.

II SECTION B. OF THE FORM MUST BE COMPLETED AND SIGNED BY THE GUARDIANSHIP CLIENT’S (STATE WARD’S) ATTENDING PHYSICIAN.

A SECOND PHYSICIAN MUST CONCUR WITH THE ATTENDING PHYSICIAN’S RECOMMENDATION FOR DNR STATUS TO BE CONSIDERED.

III ONLY PHYSICIANS MAY SIGN IN THE PHYSICIAN SIGNATURE BLOCKS.

IV IT IS ESSENTIAL THAT THE PHYSICIAN NAMES AND TITLES ARE LEGIBLE.

V ONCE THE FORM IS PROPERLY COMPLETED, PLEASE ATTACH ANY APPROPRIATE SUPPORTING DOCUMENTATION, I.E., H&P, RECENT HOSPITAL DISCHARGE SUMMARY, CONSULTATION NARRATIVES, DIAGNOSES LIST, PROGRESS NOTES (PROGNOSIS), OR ANY OTHER INFORMATION THAT MAY IMPACT THE REQUEST.

VI **THE CLIENT MUST HAVE A TERMINAL CONDITION OR BE PERMANENTLY UNCONSCIOUS TO BE CONSIDERED FOR DNR STATUS.**

VII IF THE DNR COMMITTEE ADVISES THE STATE WARD (GUARDIANSHIP CLIENT) MEETS THE CRITERIA FOR DNR, THE REQUESTING MEDICAL FACILITY WILL RECEIVE OFFICIAL NOTIFICATION, WRITTEN AND/OR VERBAL, FROM THE CABINET. **REMEMBER - THE REQUEST IS NOT APPROVED UNTIL THE REQUESTING FACILITY RECEIVES OFFICIAL NOTIFICATION FROM THE CABINET.**

THANKS IN ADVANCE FOR YOUR COOPERATION. IF YOU HAVE ANY QUESTIONS

###### PLEASE CALL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

DNR REQUEST FORM

PLEASE PRINT OR TYPE

**A. Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnoses: \_\_\_\_\_\_\_**

 **SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATTACH SUPPORTING DOCUMENTATION FROM THE MEDICAL RECORD**

Is Hospice involved in the care of this patient? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

***B. ONE OF THE FOLLOWING MUST BE CHECKED “YES” FOR DNR STATUS TO BE CONSIDERED:***

1. Is the client in a terminal condition? Yes No\_\_\_\_\_

 (A terminal condition is defined as a condition caused by injury, disease or illness which in your estimation is incurable and irreversible and will result in death within a relatively short time, and where the application of life prolonging treatment would serve only to artificially prolong the dying process.)

2. Is the client permanently unconscious? Yes No\_\_\_\_\_­

 (Permanently unconscious is defined as a condition characterized by an absence of cerebral cortical functions.)

 **REGARDLESS OF CODE STATUS,** **PALLIATIVE CARE WILL BE PROVIDED**

(Palliative care is emotional and physical support for the relief of pain and suffering. It includes but is not limited to

nutrition, hydration and comfort measures unless specific authority to withhold/withdraw nutrition and hydration has been given.)

**Recommended Code Status:**  Withhold cardiopulmonary resuscitation/DNR

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE** of Attending Physician **DATE PHONE NUMBER**

 THIS FORM CANNOT BE PROCESSED WITHOUT

**PLEASE PRINT OR TYPE NAME/TITLE** **LEGIBLE TITLES** AFTER THE PRINTED NAME

**CONSULTATIVE OPINION**

I have reviewed the medical record of and examined the above-named client.

 I **concur** with above request.

\_\_\_\_\_\_\_I **do not** concur with the above request

Comments:

**SIGNATURE of consulting Physician DATE**  **PHONE NUMBER**

THIS FORM CANNOT BE PROCESSED WITHOUT

**PLEASE PRINT OR TYPE NAME/TITLE LEGIBLE TITLES** AFTER THE PRINTED NAME

C. GUARDIAN: PLEASE PROVIDE A SUMMARY OF CLIENT’S CURRENT STATUS (i.e., ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING (ambulation, transfer, feeding, toileting, bathing), ABILITY TO COMMUNICATE, PAIN STATUS, AND ANY OTHER INFORMATION THAT MAY IMPACT THIS DECISION.

FOR STATISTICAL PURPOSES ONLY: AGE\_\_\_\_\_SEX\_\_\_\_\_RACE\_\_\_\_\_DATE OF APPOINTMENT\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_