STATE OF CONNECTICUT

Department of Developmental Services

DOCUMENTATION OF DO NOT RESUSCITATE (DNR) ORDER

Region/TS: [ ] NR [ ] SR [ ] WR [ ] STS

Regional Director Notified:   /  /     Director of Health Services Notified:   /  /

***If any NO or UNCERTAIN is checked, the Director of Health & Clinical Services and Commissioner MUST BE NOTIFIED.***

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| --- | --- | --- | --- | --- | --- |
| Name: |       | Date of Birth: |   /  /     | DDS #: |       |
| Address: |       | Agency: |       |

|  |  |
| --- | --- |
| Has the person been adjudicated incompetent? | [ ] Yes [ ] No  |
| *If yes, name of person’s guardian:* |       |
| Has the decision to place the DNR order been fully discussed with the person, family and/or guardian? | [ ]  Yes [ ] No |
| *Explain:*      |
| Is the person terminally ill (i.e., final state of an incurable or irreversible medication condition)? | [ ] Yes [ ] No [ ] Uncertain  |
| *Explain:*       |
| Is the person expected to die within days or weeks? | [ ]  Yes [ ]  No [ ]  Uncertain |

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| TREATMENT |
| Describe current treatment:       |
| Primary Physician: |       | Specialty: |       |
| Physician providing second opinion: |       | Specialty: |       |
| Is the specialty of at least one physician appropriate to the terminal diagnosis? | [ ]  Yes [ ]  No |
| Do both physicians concur that the person is in the final stages of a terminal condition? | [ ]  Yes [ ]  No |

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| REQUEST / ORDER |
| Person requesting DNR Order: |       | Relationship to person:  |       |
| Date of DNR Order: |   /  /     | Date DNR Order Reviewed:  |   /  /     |
| *Comments:*        |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature Regional Health Services/ST Medical Director: |       | Date: |   /  /     |
| Signature Regional/ST Director: |       | Date: |   /  /     |

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| Central Office Director of Health & Clinical Services Notified: |   /  /     | Faxed: |   /  /     |
| *Additional Information/Comments:*       |
| Signature Central Office Health & Clinical Services Director: |       | Date: |   /  /     |
| *Comments:*       |

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| --- | --- | --- | --- |
| Signature Commissioner: |       | Date: |   /  /     |
| *Comments:*       |

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| Director of Legal & Governmental Affairs Notified: |   /  /     | By: |       |

Distribution: Original: Person’s Medical Chart.

 Copies: Regional Health Service Director, Case Manager, and Private Agency Executive Director