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: |  | | | |

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| --- | --- | --- | --- | --- | --- |
| 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 | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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: | /  / |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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