Revised 07/2022

CONSENT REQUEST FOR OFFICE OF STATE GUARDIAN WARD DNR/DNI/WITHHOLDING/WITHDRAWAL OF TREATMENT

OSG Representative ___________________________ phone__________________fax_____________________________

This form was designed to make obtaining a Do Not Resuscitate – Do Not Intubate (DNR-DNI) order or making decisions to withhold or withdraw treatment for a ward of the Office of State Guardian (OSG) as simple as possible. All of the information requested is required to comply with OSG policy and the Illinois Health Care Surrogate Act (HCSA). OSG can only provide consent for wards who are unable to make decisions for themselves, and only when the requirements of the HCSA are met.

This completed form will be reviewed by an OSG guardianship representative who will visit the ward and contact all known family or friends. If the OSG representative recommends that consent be provided, the request will be reviewed by the OSG attorney. The OSG Administrator will make the final determination and provide signature on the consent form. Should you have any questions, please contact OSG at the phone number listed above.

1. **Attending Physician - Please fully complete sections A-D**
2. **Second Medical Opinion - Concurring Qualified Health Care Practitioner please complete Section E**

Name of Patient: ____

(A) I, _____________________________________, am the attending physician who has primary responsibility or shares responsibility for the treatment and care of the patient and am a licensed physician in Illinois or in the state where the patient is being treated.

Date form completed: ___________________

Date of last medical exam: _______________

____
Name of Hospital or Nursing Home

____
FAX

____
Signature of Physician

____
Office Address

____
City, State, Zip Code

____
Telephone

(B) DECISIONAL CAPACITY

The fact that a ward has a court-appointed guardian, or suffers from a mental illness, developmental disability or advanced age does not automatically constitute a lack of decisional capacity under the terms of the Health Care Surrogate Act. In order to make this decision on behalf of the ward, it must be determined that the patient lacks the ability to understand and appreciate the nature and consequences of decisions regarding the foregoing of life-sustaining treatment, and that the ward lacks the ability to reach and communicate an informed decision.

1. Do you feel the ward lacks decisional capacity at this time?

Circle One: YES NO **(if no is circled omit rest of form)**

2. Document patient's inability to make decisions and current cognitive status below

____

(C) PLEASE FULLY DESCRIBE THE FOLLOWING - PLEASE PRINT LEGIBLY

1. Should the patient be placed on **DNR/DNI** status which includes the withholding of all efforts to resuscitate in the event of cardiac or respiratory arrest? (check all that apply)

    a. Full Cardiopulmonary Arrest (when both breathing and heartbeat stop):

    ___ Do Not Attempt Cardiopulmonary Resuscitation (CPR)
    (Measures to promote patient comfort and dignity will be provided.)

    b. Pre-Arrest Emergency (when breathing is labored or stopped, and heart is still beating):

    SELECT ONE

    ___ Do Attempt Respiratory Resuscitation – OR-
    ___ Do Not Attempt Respiratory Resuscitation
    (Measures to promote patient comfort and dignity will be provided.)

2. Outline any medical treatment or therapy in addition to a DNR that you would like to withhold or withdraw. Explain your reasons for this action at this time. **Initial Withhold/Withdraw (if left blank, request is for DNR only)**

Treatment	W/hold	W/draw	Treatment	W/hold	W/draw
Assisted ventilation	_____	_____	Antibiotics as noted		
Renal Dialysis	_____	_____	_________________________	_____	_____
Blood Transfusions	_____	_____	Medication as noted		
Artificial Nutrition	_____	_____	_________________________	_____	_____
Artificial Hydration	_____	_____	Surgical/Other as noted		
Vasopressors	_____	_____	_________________________	_____	_____

3. Fully describe Medical Condition that supports the request for DNR/DNI/Withdraw:
(copies of progress notes or evaluations must be attached to further explain medical condition)

____

____

____

4. Are there other treatment options for the patient at this time?

    Circle One: **NO** (all other treatments are medically futile)
    YES (described below)

    ____

5. In many cases a referral for hospice services is appropriate at the time a DNR, withholding or withdrawal of treatment order is given. Is the case being referred for **hospice** care?

    Circle One: **YES**
    NO

(D) QUALIFYING CONDITION

In order to abide by the requirements of the Illinois Health Care Surrogate Act, the attending physician must document in the medical record that the patient lacks decisional capacity and that a qualifying condition exists. Check the qualifying condition that applies and is documented in the medical record. **(CHECK ONE)**

____ 1. ***"TERMINAL CONDITION"***

Where the patient has an illness or injury for which there is no reasonable prospect of recovery; and death is imminent, i.e., death will occur in a relatively short period of time, even if life sustaining treatment is initiated or continued; and the application of life-sustaining treatment would only prolong the dying process.

____ 2. ***"PERMANENT UNCONSCIOUSNESS"***

Where the patient has a condition that, to a high degree of medical certainty will last permanently, without improvement; and in which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent; and for which initiating or continuing life-sustaining treatment, in light of the ward's medical condition, provides only minimal medical benefit:

____ 3. ***"INCURABLE OR IRREVERSIBLE CONDITION"***

Where the patient has an illness or injury for which there is no reasonable prospect of a cure or recovery; and that ultimately will cause the ward's death even if life sustaining treatment is initiated or continued; and that imposes severe pain or otherwise imposes an inhumane burden on the ward; and for which initiating or continuing life-sustaining treatment, in light of the ward's medical condition, provides only minimal medical benefit.

(E) SECOND MEDICAL OPINION - CONCURRING STATEMENT OF QUALIFIED HEALTH CARE PRACTITIONER[1]

I am a physician or other qualified health care practitioner licensed to practice in Illinois or the state where the patient is being treated and I have personally examined the patient within the last 24 hours and I concur with the opinion of the attending primary physician, I concur that the patient lacks the ability to understand and appreciate the nature and consequences of decisions regarding the foregoing of life-sustaining treatment, and that the ward lacks the ability to reach and communicate an informed decision. I also concur that this request for the withholding and/or withdrawing of treatment is appropriate and warranted due to the nature of this patient's qualifying condition. I have also documented these conclusions in the patient's medical chart.

____ ____

Signature **Print Name**

_____________ ____

Date **Type of Licensure/Credentials**

[1] "Qualified health care practitioner" means an individual who has personally examined the patient and who is licensed in Illinois or in the state where the patient is being treated and who is a physician, advanced practice registered nurse, physician assistant, or resident with at least one year of graduate or specialty training who holds a temporary license to practice medicine and is enrolled in a residency program accredited by the Liaison Committee on Graduate Medical Education or the Bureau of Professional Education of the American Osteopathic Association. 755 ILCS 40/10

(F) **CONSENT OF GUARDIAN**

I, ____, a representative of the OSG, as guardian

for ____, a disabled ward, consent to

____

Treatment	W/hold	W/draw	Treatment	W/hold	W/draw
Assisted ventilation	_____	_____	Antibiotics as noted		
Renal Dialysis	_____	_____	________________________	_____	_____
Blood Transfusions	_____	_____	Medication as noted		
Artificial Nutrition	_____	_____	________________________	_____	_____
Artificial Hydration	_____	_____	Surgical/Other as noted		
Vasopressors	____	____	________________________	_____	_____

Office of State Guardian By:____ Date:_____________

THIS CONSENT IS BASED UPON THE PARTICULAR FACTS PRESENTED ABOVE AND MAY BE REVOKED AT ANY TIME IF ADDITIONAL INFORMATION IS OBTAINED OR THE PATIENT'S CONDITION SIGNIFICANTLY CHANGES. ANY REVOCATIONS WILL BE MADE VERBALLY AND IN WRITTEN FASHION TO THE TREATING PHYSICIAN. THIS CONSENT IS TO BE DOCUMENTED IN THE MEDICAL CHART OF THE PATIENT.