

**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 Physician 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.

Date form completed: _____

Signature of Physician

Date of last medical exam: _____

Office Address

Name of Hospital or Nursing Home

City, State, Zip Code

Telefax

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 communication skills, ability to make decisions and cognitive skills 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 Cardiopulmonary Resuscitation (CPR) – OR-

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

OTHER INSTRUCTIONS

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. **Circle: Withhold/Withdraw (if left blank, request is for DNR/DNI only)**

3. Fully describe Medical Condition in support of consent request,
(copies of progress notes or evaluations may 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 PHYSICIAN

I am a physician licensed to practice medicine in Illinois, 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.

Date: _____
Signature of 2nd Physician _____ Print Name of Physician _____

(F) CONSENT OF GUARDIAN

I, _____, a representative of the OSG, as guardian
for _____, a disabled ward consent to

_____ and request that this consent be documented in the medical chart of the patient.

Office of State Guardian By: _____ Date: _____

Witness: _____ 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.

Once the DNR Form is completed, fax the form to the appropriate office by county:

Regional Office	Counties Served
<p>East Central Regional Office</p> <p>2125 South 1st St Champaign, Illinois 61820 Phone: (217) 278-5577 Fax: (217) 278-5588</p>	<p>Champaign, Christian, Clark, Coles, , Crawford, Cumberland, DeWitt, Douglas, Edgar, Effingham, Ford, Iroquois, Jasper, Kankakee, Livingston, Logan, Macon, Marshal, McLean, Moultrie, Piatt, Putnam, Shelby, Vermilion and Woodford</p>
<p>Egyptian Regional Office</p> <p>#7 Cottage Drive Anna, Illinois 62906-1669 Phone: (618) 833-4897 Fax: (618) 833-5219</p>	<p>Alexander, Clay, Edwards, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Lawrence, Massac, Perry, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White and Williamson</p>
<p>Metro East Regional Office</p> <p>4500 College Avenue Suite 100 Alton, Illinois 62002-5051 Phone: (618) 474-5503 Fax: (618) 474-5517</p>	<p>Bond, Calhoun, Clinton, Fayette, Greene, Jersey, Macoupin, Madison, Marion, Monroe, Montgomery, Morgan, Pike, Randolph, Sangamon, Scott, St. Clair and Washington</p>
<p>North Suburban Regional Office</p> <p>9511 Harrison Avenue W-335 Des Plaines Illinois 60016-1565 Phone: (847) 294-4264 Fax: (847) 294-4263</p>	<p>DuPage, Lake, Northwest Cook County, plus City of Chicago North of Foster Avenue (5200 North)</p>
<p>Peoria Regional Office</p> <p>401 Main Street, Suite 620 Peoria, IL. 61602 Phone: (309) 671-3030 Fax: (309) 671-3060</p>	<p>Adams, Brown, Cass, Fulton, Hancock, Henderson, Knox, Mason, McDonough, Menard, Mercer, Peoria, Schuyler, Scott, Stark, Tazewell, Warren and Woodford</p>
<p>Rockford Regional Office</p> <p>4302 North Main Street, Suite 108 Rockford, Illinois 61103-5202 Phone: (815) 987-7657 Fax: (815) 987-7227</p>	<p>Bureau, Boone, Carroll, DeKalb, Henry, Jo Daviess, Kane, Kendall, LaSalle, Lee, McHenry, Ogle, Rock Island, Stephenson, Whiteside and Winnebago</p>
<p>West Suburban Regional Office</p> <p>Post Office Box 7009 Hines, Illinois 60141-7009 Phone: (708) 338-7500 Fax: (708)338-7505</p>	<p>Cook County south of 5200 North, Will and Grundy.</p>