

STATEMENT OF TERMINAL CONDITION

_____ has been under my medical care and has been diagnosed with the following terminal condition(s) _____

It is my professional opinion that the condition is such that death will occur within six (6) months or less regardless of the application of medical procedure.

Attending Physician _____ Date _____

Contact Number: _____

Individual/Legally Responsible Person Request

In view of the above statement, it is desired that dying not be prolonged by administration of cardiopulmonary resuscitation (CPR).

I understand that my request for a Division of DD contracted provider to comply with a non-hospital DNR order is subject to Department approval. If my request is not accepted, I have the right to appeal the decision and have been notified of the appeals process.

_____ Date _____
Competent Adult / Legally Responsible Person

FOR DMH USE ONLY

I **authorize / do not authorize** the application of a non-hospital DNR order by a Division of DD contracted/funded provider in the event cardiac and/or pulmonary arrest of the individual because of a terminal condition.

_____ Date _____
Medical Director or Designee

Comments: (more information needed, reason denied, etc.)

REVOCAION of AUTHORIZATION

I hereby revoke the above request to withhold CPR.

_____ Date: _____
Competent Adult / Legally Responsible Person