# Hospice *of* New York

## CONSENT FOR DNR ORDER FOR ADULT PATIENT LACKING CAPACITY

I, _____, understand the benefits and disadvantages of a
NAME

Do Not Resuscitate – DNR – order, as explained to me by _____ and
NAME OF PHYSICIAN

I hereby request that _____ my _____
NAME OF PATIENT RELATIONSHIP TO PATIENT

not be resuscitated if his/her heart stops beating or he/she stops breathing. I am making this decision on the basis of:

❏ the patient's known wishes, including consideration of his/her religious and/or moral beliefs;
❏ the patient's best interests, since the patient's wishes are unknown and cannot be ascertained.

**SURROGATE**

_____ _____
SIGNATURE PRINT NAME

_____ _____ _____ / /
RELATIONSHIP TO PATIENT AGE DATE

### DETERMINATION OF CAPACITY

I have examined the above named patient and have determined to a reasonable degree of medical certainty that he/she lacks the ability to understand and appreciate the nature and consequences of a DNR order, including the benefits and disadvantages. Therefore, he/she lacks the ability to reach an informed decision. In my opinion, the nature and cause of the patient's incapacity is:

_____

and its extent and probable duration are:

_____

**PHYSICIAN CERTIFICATION**

_____
SIGNATURE

_____
PRINT NAME

_____
NYS LICENSE NUMBER

_____ / / _____
DATE

**CONCURRING PHYSICIAN CERTIFICATION**

_____
SIGNATURE

_____
PRINT NAME

_____
NYS LICENSE NUMBER

_____ / / _____
DATE




ORIGINAL - Patient's Home
BLUE - Hospice Record
CANARY - Facility Copy