

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

Office of State Guardian – OSG Representative _____ a _____

Office Address: _____

City, State, Zip: _____

Phone: () - _____ Fax: () - _____

This form was designed to make obtaining a Do Not Resuscitate (DNR) 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: _____

() - _____

() - _____

Fax: _____

Phone: _____

() - _____

Fax: _____

(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?

Check One: YES NO (if no is checked omit rest of form)

2. Document patient’s communication skills, ability to make decisions and psychiatric diagnosis below.

(C) **PLEASE FULLY DESCRIBE THE FOLLOWING – PLEASE PRINT LEGIBLY**

1. Should the patient be placed on **DNR** status which includes the withholding of all efforts to resuscitate in the event of cardiac or respiratory arrest?

Check One: **YES** **NO**

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**

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?

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

Include your assessment of the benefits and risks of each option.

5. To the best of your abilities, what do you feel will cause the patient's death?

6. In many cases a referral for hospice services is appropriate at the time a DNR, withholding or withdrawal of treatment order is given. Would you like to make a referral or hospice care?

Check One: **YES** (case being referred for hospice)
 NO

Describe comfort care measures to be implemented:

7. Has an ethics committee reviewed this case?

Check One: **NO** (case considered routine, ethics consult not warranted)
 YES (consult attached **or** signature from ethics committee member noted below)

I am on the ethics committee at this facility, have met the patient and reviewed the request contained herein. I concur with the attending physician's consent request in this medical matter.

(name) (date) (phone)

(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 _____, 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: _____ / _____ / _____

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.