UNIFORM	I DNR ADVANCE DIRECTIVE 🔳 🛛	JNIFORM DNR ADVAN	CE DIRECTIVE		DNR ADVANCE	DIRECTIVE		
UNIF PHYSI	Department of Public Healt ORM DO-NOT-RESU CIAN ORDERS FOR LIFE-SU HEALTH INSURANCE PORTABILIT	SCITATE (DNF ISTAINING TREATM	IENT (POLSI	Γ)				
TO HEA	LTH CARE PROFESSIONALS AS N	ECESSARY FOR TREA	TMENT	FERIVITS DIS	GLUSURE			
orders are	Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does							
not invalid treatment	ate the form and implies initiating all for that section. With significant change n, new orders may need to be written.	Date of Birth (mm/dd/yy)			Gender			
See also C	See also Guidance for Health Care Professionals at http://www.idph.state.il.us/public/books/advin.htm. Address (street/city/state/ZIPcode)							
Α	CARDIOPULMONARY RESUS	CITATION (CPR) Pat	ient has no pu	ulse <i>and</i> is no	ot breathing.			
Check	Attempt Resuscitation/CPR (Se	-	on and Mechanic	al Ventilation in S	Section B is selected	d)		
One	Do Not Attempt Resuscitation/I	ONR						
	When not in a	cardiopulmonary arre	st, follow orde	ers B and C.				
В	MEDICAL INTERVENTIONS	Patient has pulse and	/or is breathin	g.				
Check One Do Not Attempt Resuscitation/DNR When not in cardiopulmonary arrest, follow orders B and C. B MEDICAL INTERVENTIONS Patient has pulse and/or is breathing. Check One Comfort Measures Only (Allow Natural Death). Relieve pain and suffering through the use of medication appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatme airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatment in current location. Treatment Plan: Maximize comfort through symptom management. Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment plan: Provide basic medical treatments. Intubation and Mechanical Ventilation In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care described in Comfort Measures Only and Limited Additional Interventions In addition to care descri						nent of eatments.		
	 Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). <i>Transfer to hospital if indicated. Generally avoid the intensive care unit.</i> Treatment Plan: Provide basic medical treatments. Intubation and Mechanical Ventilation In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. <i>Transfer to hospital and/or intensive care unit if indicated.</i> Treatment Plan: Life support measures, including intubation, in the intensive care unit. 							
	Additional Orders							
C	ARTIFICIALLY ADMINISTERED	ONUTRITION Offer 1	ood by mouth	i, if feasible a	nd as desired.			
Check	Additional Orders ARTIFICIALLY ADMINISTERED NUTRITION Offer food by mouth, if feasible and as desired. Additional Instructions (e.g., length of trial period) Defined trial period of artificial nutrition by tube.							
One (optional)	Defined trial period of artificial nu							
(-)	Long-term artificial nutrition by tu							
D	DOCUMENTATION OF DISCUS		-					
	□ Patient	-	health care pow	-		P . 0		
	Parent of minor	n maker (See F	maker (See Page 2 for priority list)					
	Signature of Patient or Legal Rep	resentative			Det			
	Signature (required)		Name (print)		Date			
	Signature of Witness to Consent I am 18 years of age or older and ackn giving of consent by the above person of	owledge the above person	has had an opport					
	Signature (required)		Name (print)		Date			
Е	SIGNATURE OF ATTENDING PHYSICIAN My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.							
			e orders are consiste	Phone	medical condition and	preierences.		
	Print Attending Physician Name (required)			_ ()				
	Attending Physician Signature (requ	uired)	Date (requir	red)	Page 1			
						X		

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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THIS SIDE FOR INFORMATIONAL PURPOSES ONLY

Patient	Last	Name
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FORM DNR ADVANCE DIRECTIVE

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Patient First Name

The Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive is **always voluntary** and is for persons with advanced or serious illness or frailty. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)					
Health Care Power of Attorney	Living Will Declaration	Mental Health Treatment Preference Declaration			
Contact Person Name		Contact Phone Number			
	Health Care Professional Inform	nation			
Preparer Name		Phone Number			
Preparer Title		Date Prepared			

Completing the IDPH Uniform Do Not Resuscitate (DNR) Advance Directive Form

- The completion of a DNR form is always voluntary, cannot be mandated and may be changed at any time.
- · A DNR form should reflect current preferences of persons with advanced or serious illness or frailty. Also, encourage completion of a POAHC.
- · Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy.
- · Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a Do Not Resuscitate (DNR) Advance Directive Form

This DNR form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another,
- · or there is a substantial change in the patient's health status,
- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR) Advance Directive Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR form requires completion of a new DNR form.
- Draw line through sections A through E and write "VOID" in large letters if any DNR form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- · If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

- 1. Patient's guardian of person
- 2. Patient's spouse or partner of a registered civil union
- 3. Adult child
- 4. Parent

- 5. Adult sibling
- 6. Adult grandchild
- 7. A close friend of the patient
- 8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at http://www.idph.state.il.us/public/books/advin.htm

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

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