DO NOT RESUSITATE (DNR)) REQUEST FORM

1. DETAILS OF PERSON MAKING THE REQUEST

NAME :

MYKAD / PASSPORT NUMBER :

SEX *(please tick)* : MALE **[ ]** FEMALE **[ ]**

DATE OF BIRTH : __ __ - __ __ - __ __ *(must be at least 21 years old)*
day month year

ADDRESS :

1. I, *name and MyKad/Passport number as above,* who is the (*state relation to patient*) …… of (*Patient's name*) ……..…….. with MyKad / Passport…….., hereafter to be known as "Patient" hereby give my consent that no extraordinary life-sustaining treatment should be applied or given to the Patient.
2. I understand that *"terminal illness*" means an incurable condition caused by injury or disease from which there is no reasonable prospect of a recovery where :-
   a) Death would within reasonable medical judgment be imminent regardless of the application of extraordinary life-sustaining treatment(s).
   b) The application of life-sustaining treatment(s) would only serve to extend the dying process with little or no hope of recovery.
3. I understand that "life-sustaining treatment" means any medical procedure or measure which, when administered to terminally ill patient, will only prolong the process of dying when death is imminent, excluding palliative care.
4. This consent shall not affect any right, or duty which a medical practitioner or any other person has in giving palliative care, including the provision of reasonable medical procedure(s) to relieve pain, suffering or discomfort.

Care provider as appropriate **WILL** provide:	Care provider will **NOT**:
• Clear airway • Administer oxygen • Position for comfort • Splint • Control bleeding • Provide pain medication • Provide emotional support • Contact hospice or home health agency if either has been involved in patient's	• Perform chest compressions • Insert advanced airways • Administer cardiac resuscitation drugs • Provide ventilator assistance • Defibrillate

5. I understand I may revoke this directive at any time by notifying the consultant in charge in writing to remove the "DNR" request.
6. In consideration of utilizing this DNR request I, on behalf of myself and my family members, release any claim for damages resulting from such action against the consultant(s) in-charge, nursing staff and the hospital.
7. This consent is made in the presence of a witness.

Name & Signature / Thumbprint:
Date & Time

2. CONSULTANT'S DECLARATION:

1. I have taken reasonable steps to ensure that the maker of this request:-
   a) Is of *sound mind;
   b) Has attained the age of 21 years;
   c) Has made the consent voluntarily and without inducement or compulsion; and
   d) Has been informed of the nature and consequences of making the consent.

2. I declare that the consent is made and signed in my presence together with the witness named below.

I, have to the best of my ability explained to the person making the request (Name)……., the condition of the patient in detail and the reason for no active resuscitation is as the patient is "terminally ill". I have permitted time and opportunity for him/her to ask questions and all questions have been answered to my knowledge.
I affirm that he/she is making an informed decision and that this directive is his/her expressed wish.

I declare that this request is made and signed in my presence together with the witness named below.

SIGNATURE, DATE & TIME:

**Note: As a guide for the purposes of determining whether the maker of the consent is of sound mind, the Consultant should ascertain whether the maker:-*

a) Understands the nature and implications of the request;
b) Is oriented to time and space; and
c) Is able to name himself and his immediate family members.

3. WITNESS DECLARATION:

I have accurately read or witnessed the accurate reading of the request form to the requestor, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

NAME : _____

MYKAD / PASSPORT NUMBER : _____

HOME ADDRESS : _____

_____

MOBILE TELEPHONE : _____ **HOME / OFFICE TELEPHONE** : _____

SIGNATURE, DATE & TIME:

Note: A witness shall be a person who to the best of his knowledge:-

*a) This witness must be of at least 21 years of age and of sound mind**
b) Is not a beneficiary under the Patient's will or any policy of insurance;
c) Has no interest under any instrument under which the Patient is the donor, settler or guarantor;
d) Would not be entitled to an interest in the estate of the Patient on the Patient's death intestate.