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|  | **CLINICAL SUPPORT SERVICES**  **HOSPITAL PENGAJAR UPM** |
| **DECISION ON LIFE SUSTAINING TREATMENT**  **(Individual Age 18 Years Old and Above)** |

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| **SECTION 1: PATIENT DETAILS** | | | **Date of DNACPR decision:**  **/ /** |
| Name : | | |
| IC/Pasport No : | | |
| UPM No : | Age : | | **DO NOT PHOTOCOPY** |
| Date of Birth : | Gender : | |
| **SECTION 2 : DIAGNOSIS \*(Please provide relevant details)** | | | |
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| **SECTION 3 :** | | | |
| Life sustaining treatment (s) is supportive treatment of various internal organs to keep the patient alive. Nevertheless, in certain circumstances, these treatment (s) is/are no longer offer benefit to patient, or no longer needed.  1. In the event or acute significant deteroriation (non arrest).  A) Continue all life sustaining treatment.  B) Continue treatment for symptom control only (for patient comfort). (DNACPR should be decide).  C) To continue other treatment and care but to WITHOLD/WITHDRAW the following life sustaining treatment as below: | | | |
| Invasive Mechanical Ventilation  Non Invasive Mechanical Ventilation  Administration of Vasoactive Treatment | | Renal Replacement Therapy (RRT)  Artificially Administered Feeding  Blood Transfusion | |
| Surgery (Please provide relevant details) : | | | |
| Others (Please provide relevant details) : | | | |
| 2. Please state the reason for withholding the treatment :  A) Life sustaining treatment is unable or unlikely to prolong life significantly and may not be in the individual's best interest.  B) Life sustaining treatment may be able to prolong life but will not significantly improve quality of life and will not alleviate the burdens associated with illness or treatment itself.  C) Others (Please provide relevant details) : | | | |
| DNACPR order in place? Yes No Date of Decision : | | | |

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| **SECTION 4: HEALTHCARE PROFESSIONAL MAKING THIS DECISION** | | |
| **Healthcare Professional Recording this decision**  (Note: Medical Officer's signature must be endorsed by Specialist/Consultant) | | **ENDORSED BY:**  (Specialist/Consultant) |
| Name :  Position :  Date :  Time :  …................................................................  (Sign and Stamp) | | Name :  Position :  Date :  Time :  …................................................................  (Sign and Stamp) |
| **SECTION 5 : COMMUNICATION WITH PATIENT/PATIENT'S NEXT OF KIN (NOK)** | | |
| **(Please explain to patient/patient's NOK the reason of Do Not Attempted CPR apply, unless doing so would cause unnecessary distress)**  **Patient has the mental capacity to involve in the discussion. YES ( ) NO ( )**  **Patient involve in discussion. YES ( ) NO ( )** | | |
| Name : | Date & Time of Discussion : | |
| Relationship: | IC/Pasport No of Patient/NOK : | |
| Signature of patient/NOK : | Witness by (Name & Stamp) : | |
| If no discussion being made with patient/patient's NOK, please justify the reasons : | | |