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| A red and white sign  Description automatically generated with medium confidence | **CLINICAL SUPPORT SERVICES**  **HOSPITAL PENGAJAR UPM** |
| **BORANG *DO NOT ATTEMP CARDIOPULMONARY RESUSCITATION* (*DNACPR*) DEWASA**  **(Individu Berumur 18 Tahun dan Ke Atas)** |

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| **Sekiranya berlaku *cardiac* atau *respiratory arrest*, prosedur *Cardiopulmonary Resuscitation* (CPR) tidak akan dilakukan. Semua rawatan dan penjagaan lain yang sesuai akan diberikan** | | | | |
| **SEKSYEN 1: BUTIRAN PESAKIT** | | | | **Tarikh DNACPR:**  **/ /** |
| Nama: | | | |
| KP/Passport No: | | | |
| UPM No: | Umur: | | | **SALINAN BORANG ADALAH DILARANG** |
| Tarikh Lahir: | Jantina: | | |
| **SEKSYEN 2: DIAGNOSIS \*(Sila nyatakan maklumat yang berkaitan)** | | | | |
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| **SEKSYEN 3: SEBAB *DNACPR*** | | | | |
| CPR tidak dapat memanjangkan jangka hayat dan tidak bermanfaat kepada pesakit. (Sila nyatakan maklumat yang berkaitan) | | | | |
| CPR mungkin boleh memanjangkan jangka hayat tetapi tidak boleh memperbaiki kualiti hidup pesakit dan  tidak meringankan beban terhadap penyakit dan juga rawatan kepada pesakit. (Sila nyatakan maklumat yang berkaitan) | | | | |
| Lain-lain: (Sila nyatakan maklumat yang berkaitan) | | | | |
| **SEKSYEN 4 : Pegawai/Pakar Perubatan yang Melengkapkan dan Mengesahkan Keputusan *DNACPR*** | | | | |
| **Pegawai Perubatan yang melengkapkan borang :**  (Note: Tandatangan Pegawai Perubatan perlu disahkan oleh Pakar/Pakar Perunding) | | | **Disahkan Oleh:**  (Pakar/Pakar Perunding) | |
| Nama:  Jawatan:  Tarikh:  Masa:  …................................................................  (Tandatangan dan Cap) | | | Nama:  Jawatan:  Tarikh:  Masa:  …................................................................  (Tandatangan dan Cap) | |
| **SEKSYEN 5 : PERBINCANGAN BERSAMA PESAKIT/WARIS** | | | | |
| **(Penjelasan DNACPR perlu diberikan kepada pesakit/waris, kecuali jika melakukannya akan menyebabkan kesulitan)**  **Pesakit mempunyai keupayaan mental untuk terlibat dalam perbincangan. YA ( ) TIDAK ( )**  **Pesakit terlibat dalam perbincangan. YA ( ) TIDAK ( )** | | | | |
| Nama: | | Tarikh & Masa: | | |
| Hubungan: | | KP/Pasport No Pesakit/Waris : | | |
| Tandatangan Pesakit/Waris : | | Saksi (Nama & Cop): | | |
| Sekiranya tidak ada perbincangan bersama pesakit/waris, sila nyatakan alasannya: | | | | |
| **JIKA SEMAKAN DNACPR DILAKUKAN- BUAT DUA GARISAN DI ATAS BORANG.**  **SILA TULIS NAMA, TARIKH, TANDATANGAN DAN ALASAN PEMBATALAN** | | | | |

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| A red and white sign  Description automatically generated with medium confidence | **CLINICAL SUPPORT SERVICES**  **HOSPITAL PENGAJAR UPM** |
| **ADULT DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) FORM**  **(Individual Age 18 years old and above)** |

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| **In the event of cardiac or respiratory arrest, no attempt of CPR will be made.**  **All other appropriate treatment and care will be provided** | | | | |
| **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: REASON FOR DNACPR** | | | | |
| CPR is unable or unlikely to prolong life significantly and may not be in the patient's best interest. (Please provide relevant details) | | | | |
| CPR 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: (Please provide relevant details) | | | | |
| Others: \*(Please provide relevant details) | | | | |
| **SECTION 4: HEALTHCARE PROFESSIONAL MAKING THIS DNACPR 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 ( )**  **Patients involve in discussion. YES ( ) NO ( )** | | | | |
| Name: | | Date & Time: | | |
| 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: | | | | |
| **IF REVISION OF DNACPR IS MADE - CLEARLY CROSS THROUGH THIS DOCUMENT WITH 2 LINES.**  **PLEASE WRITE NAME, DATE, SIGNATURE AND REASON FOR CANCELLATION** | | | | |