Adults aged 18 and over Nottingham University Hospitals NHS

NHS Trust

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Name _____

Address _____

Date of Birth _____

NHS / Hospital No. _____

Ward / Department _____

Date of DNACPR decision

/ /

RED BORDER COPY IS ORIGINAL

Photocopies are in black & white

Send carbon-copy to resuscitation dept.

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation will be made. All other appropriate treatment and care will be provided

1 Does the patient have capacity to make and communicate decisions about CPR?

If "YES" go to box 2 — **YES / NO**

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If "YES" go to box 6 — **YES / NO**

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted. — **YES / NO**

All other decisions must be made in the patient's best interests and comply with current law. Go to box 2.

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccesful, or not in the patient's best interests:

3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient (or Welfare Attorney) state the reason why:

4 Summary of communication with patient's relatives or friends:

5 Name of the senior nurse & mulitidisciplinary team contributing to this decision:

Please ensure nursing staff are informed of this DNACPR decision

6 Healthcare professional completing this DNACPR order:

Name: _____ Position: _____

Signature: _____ Date: _____ / _____ / _____ Time: _____

7 Review and endorsement by most senior health professional: **Review Date (if appropriate):**

Signature: _____ Name: _____ Date: _____ / _____ / _____

Signature: _____ Name: _____ Date: _____ / _____ / _____

8 Is it the intention that this DNACPR decision is to be valid after discharge or transfer?

If "YES", the patient must be aware. The GP or team taking over the patient's care must be aware. This form may go with the patient. A photo-copy must be placed in the patient's notes.

YES / NO

Signature: _____

Name: _____

Date: _____ / _____ / _____

If "NO", cancel this form (draw 2 diagonal lines and write "CANCELLED" and file in the patients notes. The patient will be FOR CPR once they leave the hospital.

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