SUNY DOWNSTATE Medical Center | University Hospital of Brooklyn

Name	
MR#:	DOB:

PATIENT CONSENT TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING TREATMENT

PATIENT'S CONSENT

1. I have discussed this decision with Dr. _____, who has informed me of my diagnosis and prognosis, and who has explained to me the risks, likely benefits and the alternatives to this decision to withdraw or withhold life-sustaining care. I have had an opportunity to ask questions and my questions have been answered to my satisfaction. I have also had enough time to think about this decision and to consult with others if I wish to do so.

2. **I am making the following decisions:**

   ☐ **I consent to withdraw or withhold the following life-sustaining treatment(s) *before* my heart or breathing stops:**

   _____

   _____

   _____

   ☐ **I consent to an order not to attempt resuscitation (a DNR Order) if my heart or breathing stops.**

The patient may sign below, but if consent is oral, an attending physician must indicate that the decision was oral by printing the patient's name in this box, and by checking the appropriate box and signing in the Attending Physician's Statement below.

Patient's Name (Print)	Patient's Signature	Date and Time

ATTENDING PHYSICIAN'S STATEMENT

☐ **I have witnessed the patient's <u>oral</u> decision to withhold or withdraw the life-sustaining treatment that is indicated in paragraph 2, above; OR**

☐ **I have witnessed the patient's <u>written</u> decision to withhold or withdraw the life-sustaining treatment that is indicated in paragraph 2, above.**

Attending Physician's Name (Print)	Signature	Date and Time

WITNESS' SIGNATURE (Any hospital employee.)

☐ **I have witnessed the patient's <u>oral</u> decision to withhold or withdraw the life-sustaining treatment that is indicated in paragraph 2, above; OR**

☐ **I have witnessed the patient's <u>written</u> decision to withhold or withdraw the life-sustaining treatment that is indicated in paragraph 2, above.**

Witness' Name (Print)	Signature	Date and Time

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