HOME AND COMMUNITY CARE SUPPORT SERVICES
Hamilton Niagara Haldimand Brant

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Hamilton Niagara Haldimand Brant

Plan of Treatment Regarding Cardiopulmonary Resuscitation (CPR)

Patient Information

Name _____ **HCN** _____ **VC** ____ **DOB** _____

Address _____ **City** _____ **Province** _____

Postal Code _____ **Phone #** _____ **BRN #** _____

Contact Name(s) _____ **Contact Phone #** _____

Most Responsible Practitioner (MD/NP) and Substitute Decision Maker (SDM) Information

MRP _____ **MRP aware of Plan of Treatment regarding CPR?** ☐**Yes** ☐**No**

Is the person capable with respect to the CPR / No CPR (allow natural death) decision? ☐**Yes** ☐**No**

Determined by _____ **Date** _____

If person is incapable with respect to the CPR / No CPR decision, determine the lawful SDM

SDM Name _____ **Contact Number** _____

SDM Name _____ **Contact Number** _____

Plan of Treatment Information – please choose one of the following options

☐ **CPR – Provide full treatment and resuscitation.** CPR may involve the following interventions: chest compression, defibrillation, and artificial ventilation, insertion of an oropharangeal or nasopharangeal airway, endotracheal intubation, transcutaneous pacing, and drugs such as vasopressors, antiarrythmic agents, and opioid antagonists.

☐ **No CPR/Allow Natural Death.** The person is treated with dignity and respect and kept clean, warm and dry. Pain and symptom management and spiritual and psychosocial support are provided. Reasonable measures are made to offer food and fluids by mouth. Medication, positioning, wound care and other measures are used to relieve pain and suffering.

Regulated Health Professional Completing this Form

☐ Verbal consent to the above plan of treatment has been received. The possible side effects and benefits of CPR have been explained and any questions have been addressed.

Consent obtained by _____ **Title** _____ **Date** _____

Information received from _____ **Relationship to patient** _____

Optional - Patient/SDM to sign: ☐ **The above states my wishes** _____**Date** _____

Mandatory - Signature for Regulated Health Professional Completing this form:

Signature _____ **Date** _____

Additional Information

A copy of this form is to be kept with the patient and a copy is to be sent to the HCCSS HNHB and shared with all service providers. This plan of treatment can be reviewed and revoked at any time.

Do Not Resuscitate Confirmation (DNR-C) Form Completed: ☐**Yes** ☐**No**

Fax Completed Form to:

☐ Hamilton	☐ Niagara	☐ Haldimand-Norfolk	☐ Brant	☐ Burlington
Fax: 905 574 6335	Fax: 905 684 8463	Fax: 519 426 4384	Fax: 519 759 7130	Fax: 905 639 0129

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