VERMONT
DEPARTMENT OF HEALTH

INSTRUCTIONS FOR CLINICIANS
COMPLETING VERMONT DNR/COLST FORM
(DO NOT RESUSCITATE ORDER/CLINICIAN ORDERS FOR LIFE SUSTAINING TREATMENT)

Completing DNR/COLST

- The DNR/COLST form must be completed and signed by a health care clinician based on patient preferences and medical indications. A clinician is defined as a medical doctor, osteopathic physician, advance practice registered nurse or physician assistant. 18 V.S.A. § 9701(5). Verbal orders are acceptable with follow-up signature by the clinician in accordance with facility/community policy.
- Photocopies and Faxes of signed COLST forms are legal and valid; use of original is encouraged.

Special requirements for completing the DNR section of COLST (18 V.S.A. §§9708, 9709)

- A DNR order may be written on the basis of either informed consent or futility. Complete section A-2 for informed consent; Section A-3 for futility.
- An order based on informed consent must include the name of the patient, agent, guardian, or other individual giving informed consent. Beginning January 2018, the name of the patient, agent, guardian, or surrogate.
- An order based on futility must include a certification by the clinician and a second clinician that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest.
- If patient is in a health care facility, the clinician must certify that the requirements of the facility's DNR protocol as required by 18 V.S.A. § 9709 have been met
- The clinician shall authorize the issuance of a DNR identification to the patient
- Clinician must certify that clinician has consulted or made an attempt to consult with the patient, and the patient's agent or guardian.

Using DNR Order - Section A CPR/DNR - 18 V.S.A. § 9708(i) and (l)

- A DNR Order (Section A of the DNR/COLST form) only precludes efforts to resuscitate in the event of cardiopulmonary arrest and does not affect other therapeutic interventions that may be appropriate for the patient. (Sections B through H of the COLST Form address other interventions.)
- Health care professionals, health care facilities, and residential care facilities must honor a DNR order or a DNR Identification unless the professional or facility believes in good faith, after consultation with the patient, agent or guardian, where possible and appropriate
    - that the patient wishes to have the DNR Order revoked, or
    - that the patient with the DNR identification or order is not the individual for whom the DNR order was issued.

  Documentation of basis for belief in medical record is required.

Using COLST (Sections B through H)

- Any section of COLST not completed indicates that the COLST order does not address that topic. It may be addressed in a patient's advance directive, or in other parts of the medical record.
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only", may be transferred to a setting able to provide comfort.
- Treatment of dehydration is a measure that may prolong life. For a patient who desires IV fluids the order should indicate "Limited Interventions" or Full Treatment."
- A patient with or without capacity, or another person authorized to provide consent, may revoke the COLST order at any time and request alternative treatment. Exceptions may apply. See, 18 V.S.A. § 9707(h) or 18 V.S.A. § 9707(g).
- Photocopies and faxes of signed DNR/COLST forms are legal and valid; use of original is encouraged.

Documenting Clinician's Verbal Order (Sections A6 & H)

To document a clinician's verbal order for a DNR/COLST:

- The patient's nurse or social worker must print the clinician's name in **Section A6 for DNR** and/or **Section H for COLST** and write "Verbal Order" on the clinician signature line.
- The nurse or social worker documenting the verbal order must also sign and date the form.
- A duplicate DNR/COLST must be completed and sent to the clinician for an original signature.
- At the earliest convenience, the order with the original signature must be returned to the patient to replace the previously documented verbal order.

Reviewing DNR/COLST

This form should be reviewed periodically and a new form completed if necessary when:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient's health status, or
3. The patient's treatment preferences change, or
4. At least annually, but more frequently in residential or inpatient settings.

Voiding DNR/COLST

To void this form or a part of it, draw a line through each page or section to be voided and write "VOID" in large letters.

Patient Name / D.O.B._____/_____

DNR/COLST

CLINICIAN ORDERS for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

FIRST follow these orders, **THEN** contact **Clinician.**

Patient Last Name
Patient First/Middle Initial
Date of Birth

(If patient/resident has no pulse and/or no respirations)

A

DO NOT RESUSCITATE (DNR)

☐ **DNR/Do Not Attempt Resuscitation (Allow Natural Death)**

CARDIOPULMONARY RESUSCITATION (CPR)

☐ **CPR/Attempt Resuscitation**

For patient who is breathing and/or has a pulse, GO TO SECTION B – G, PAGE 2 FOR OTHER INSTRUCTIONS. CLINICIANS MUST COMPLETE SECTIONS A-1 THROUGH A-5

A-1 Basis for DNR Order
Informed Consent - Complete Section A-2
Futility - Complete Section A-3

A-2 Informed Consent

Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

_____ _____
Name of Person Giving Informed Consent (Can be Patient) Relationship to Patient (Write "self" if Patient)

_____
Signature (If Available)

A-3 Futility (required if no consent)

☐ I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined:

_____ _____
Name of Other Clinician Making this Determination (Print here) Signature of Other Clinician

Dated:_____

A-4 Facility DNR Protocol (required if applicable)

This patient is ☐ is not ☐ in a health care facility or a residential care facility.

Name of Facility:_____

If this patient is in a health care facility or a residential care facility, the requirements of the facility's DNR protocol have been met._____ (Initial here if protocol requirements have been met.)

A-5 DNR Identification (optional)

I have authorized issuance of a DNR Identification (ID) to this patient. Form of ID:_____

Certification and signature for DNR

A-6 Clinician Certifications and Signature for CPR/DNR (required)

I have consulted, or made an effort to consult with the patient and the patient's agent or guardian.

Patient's Agent or Guardian_____ Address or Phone_____

I certify that I am the clinician for the above patient, and I certify that the above statements are true.

_____ _____
Signature of Clinician Printed Name of Clinician

Dated:_____

GIVE COPY TO PATIENT AND REPRESENTATIVE
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Patient Name / D.O.B._____/_____

HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT
(If patient/resident is breathing and/or has pulse)

B **INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS:**

If patient has DNR order and has progressive or impending pulmonary failure without acute cardiopulmonary arrest:

- ☐ Do Not Intubate/Multi-Lumen Airway (DNI)
- ☐ Trial Period of Intubation/Multi-Lumen Airway and ventilation
- ☐ Intubation/Multi-Lumen Airway and long-term mechanical ventilation if needed

C **TRANSFER TO HOSPITAL**

- ☐ Do not transfer unless comfort care needs cannot be met in current location or if severe symptoms cannot be otherwise controlled
- ☐ Transfer

D **ANTIBIOTICS**

- ☐ No antibiotics. Use other measures to relieve symptoms
- ☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal
- ☐ Use antibiotics

E **ARTIFICIALLY ADMINISTERED NUTRITION:** Offer food and liquids by mouth if feasible.

Feeding tube

- ☐ No feeding tube
- ☐ Trial period of feeding tube (Goal:_____)
- ☐ Long-term feeding tube

Parenteral nutrition or hydration (e.g. IV fluids or Total Parenteral Nutrition)

- ☐ No parenteral nutrition or hydration
- ☐ Trial period of parenteral nutrition or hydration (Goal:_____)
- ☐ Long term parenteral nutrition or hydration

F **MEDICAL INTERVENTIONS:**

- ☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Offer food and fluids by mouth, if feasible.
- ☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatments and IV fluids as indicated. *Avoid intensive care if possible.*
- ☐ **FULL TREATMENT** Includes care described above. Use defibrillation and intensive care as indicated.

G **Other Instructions** :

GIVE COPY TO PATIENT AND REPRESENTATIVE
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Patient Name / D.O.B._____/_____

HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

H **Informed Consent and Clinician Signature for COLST Order (Sections B through G)**

Informed Consent for this COLST Order has been obtained from:

_____ _____

Name of Person Giving Informed Consent (Patient if competent) | Relationship to Patient (Write "self" if Patient)

_____

Signature

Clinician Signature for COLST

_____ _____

Signature of Clinician | Printed Name of Clinician

Dated:_____

Print Clinician Name	Clinician Signature (mandatory)	Phone Number
Person providing consent's signature (if available)		Date

Other Contact Information (Optional)

Name of Guardian, Agent or other Contact Person	Relationship	Phone Number

Name of Health Care Professional Preparing Form	Preparer Title/Facility	Phone Number	Date Prepared

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ New form completed ☐ Form Voided
			☐ No Change ☐ New form completed ☐ Form Voided
			☐ No Change ☐ New form completed ☐ Form Voided

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED