CODE STATUS PROGRESS NOTE
(Insert in sequence in Progress Note section)

BOTH SIDES OF THIS FORM MUST BE COMPLETED IN FULL, INCLUDING LEGIBLE SIGNATURES, WITH EACH CHANGE IN A PATIENT’S CODE STATUS TO DO NOT RESUSCITATE, DO NOT INTUBATE OR LIMITED CARDIOPULMONARY RESUSCITATION STATUS.

CODE STATUS:
☐ DO NOT RESUSCITATE
☐ DO NOT INTUBATE
☐ LIMITED CARDIOPULMONARY RESUSCITATION
☐ Withhold Antiarrhythmics
☐ Withhold Intravenous Vasoactive Drugs
☐ Withhold Defibrillation/Cardioversion
☐ Withhold Chest Compression
☐ Withhold Ventilation by Mask
☐ Withhold Endotracheal Intubation
☐ Withhold Mechanical Ventilation
☐ Withhold Other CPR Measures (specify)

1. DIAGNOSIS: _____________________________________________________________________________

2. PROGNOSIS/BASIS FOR PROGNOSIS: ______________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________

3. PATIENT’S DECISION MAKING CAPACITY: ☐ PRESENT ☐ ABSENT ☐ VARIABLE

4. REASON FOR PATIENT’S DECISION MAKING CAPACITY BEING ABSENT OR VARIABLE: __________
   _______________________________________________________________________________________

5. REASON(S) FOR DNR/DNI/LCPR ORDER: (check all that apply)
☐ PATIENT’S CONDITION IRREVERSIBLE, DEATH IMMINENT/LIMITED LIFE EXPECTANCY
☐ REQUESTED BY PATIENT BECAUSE: _____________________________________________________________________________
☐ REQUESTED BY SURROGATE BECAUSE: _____________________________________________________________________________
☐ ADVANCE DIRECTIVE (specify) _____________________________________________________________________________
☐ OTHER (specify) _____________________________________________________________________________

(Continued on reverse side)
6. DISCUSSION OF CODE STATUS HAS OCCURRED WITH: (check all that apply)
   - PATIENT
   - FAMILY (specify) ____________________________________________________________
   - NURSING STAFF (specify) __________________________________________________
   - HOUSESTAFF (specify) _____________________________________________________
   - CONSULTING PHYSICIAN(S) (specify) _________________________________________
   - OTHER (specify) ___________________________________________________________

7. DISCUSSION OF CODE STATUS WAS PERFORMED BY: (check all that apply)
   - ATTENDING PHYSICIAN
   - CONSULTING PHYSICIAN(S) (specify) _________________________________________
   - HOUSESTAFF (specify) _____________________________________________________
   - NURSING STAFF (specify) __________________________________________________
   - OTHER (specify) ___________________________________________________________

8. DISCUSSION OF CODE STATUS HAS NOT TAKEN PLACE WITH (circle all that apply) COMPETENT PATIENT/THE FAMILY/SURROGATE BECAUSE: __________________________________________________
    _________________________________________________________________________
    _________________________________________________________________________
    _________________________________________________________________________

9. TREATMENT GOALS (corresponding Orders should be written as applicable):
   - EMPHASIS ON COMFORT CARE
   - TREAT ACUTE REVERSIBLE PROCESSES (e.g., infection, GI obstruction)
   - PROCEED WITH CURRENT THERAPY (e.g., chemotherapy, blood transfusions, dialysis)
   Explain: ___________________________________________________________________
   _________________________________________________________________________

10. SUMMARY STATEMENT / ADDITIONAL COMMENTS: ________________________________
    _________________________________________________________________________
    _________________________________________________________________________
    _________________________________________________________________________
    _________________________________________________________________________
    _________________________________________________________________________
    _________________________________________________________________________

ATTENDING PHYSICIAN’S SIGNATURE: ____________________________________________

DATE: __________________________          TIME: __________________________