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|  | **CLINICAL SUPPORT SERVICES**  **HOSPITAL PENGAJAR UPM** |
| **PEDIATRIC DECISION ON LIFE SUSTAINING TREATMENT**  **(Individual age less than 18 years old)** |

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| **SECTION 1: PATIENT DETAILS** | | | **Date :**  **/ /** |
| Name : | | |
| IC/Pasport No : | | |
| UPM No : | Age : | | **DO NOT PHOTOCOPY** |
| Date of Birth : | Gender : | |
| **SECTION 2 : DIAGNOSIS (Please provide relevant details)** | | | |
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| **SECTION 3 : LIFE SUSTAINING TREATMENT** | | | |
| Life sustaining treatment (s) is supportive treatment of various internal organs to keep the patient alive. Nevertheless, in certain circumstances, these treatment (s) is/are no longer offer benefit to patient, or no longer needed.  1. In the event or acute significant deteroriation (non arrest).  A) Continue all life sustaining treatment.  B) Continue treatment for symptom control only (for patient comfort). (DNACPR should be decide).  C) To continue other treatment and care but to **WITHOLD/WITHDRAW** the following life sustaining treatment as below: | | | |
| Invasive Mechanical Ventilation  Non Invasive Mechanical Ventilation  Administration of Vasoactive Treatment | | Renal Replacement Therapy (RRT)  Artificially Administered Feeding  Blood Transfusion | |
| Surgery (Please provide relevant details) : | | | |
| Others (Please provide relevant details) : | | | |
| 2. Please state the reason for withholding the treatment :  A) Life sustaining treatment is unable or unlikely to prolong life significantly and may not be in the individual's best interest.  B) Life sustaining treatment may be able to prolong life but will not significantly improve quality of life and will not alleviate the burdens associated with illness or treatment itself.  C) Others (Please provide relevant details) : | | | |
| DNACPR order in place? Yes No Date of Decision : | | | |

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| **SECTION 4: HEALTHCARE PROFESSIONAL COMPLETING THIS DECISION FOR LIFE SUSTAINING TREATMENT** | | |
| **Healthcare Professional Recording This Decision**  (Note: Medical Officer's signature must be endorsed by Specialist/Consultant) | | **ENDORSED BY:**  (Specialist/Consultant) |
| Name :  Position :  Date :  Time :  …................................................................  (Sign and Stamp) | | Name :  Position :  Date :  Time :  …................................................................  (Sign and Stamp) |
| **SECTION 5 : SIGNATURE OF PARENT/PERSON HOLDING PARENTAL RESPONSIBILITY** | | |
| Name : | Date & Time of Discussion : | |
| Relationship: | Ic/Pasport No of Parent/Person holding responsibility: | |
| Signature : | Witness by (Name & Stamp) : | |