DO NOT RESUSCITATE REQUEST/ORDER

I, ______________________________, hereby affirm my understanding of the following
Print Patient Name
as herein described as permitted by state law and regulation.

- I understand "DO NOT RESUSCITATE" means that if my heart stops beating or if I stop breathing, no medical treatment will be started or continued.
- I understand this decision will not prevent me from obtaining emergency medical care by paramedics and other medical care prior to my death at the direction of my physician.
- I understand I may revoke this directive at any time.
- As permitted by state law and regulation, I give permission for this information to be given to paramedics, doctors, nurses, or other health personnel as necessary to implement these directives.

Patient must initial statement.

I ❑ DO ❑ DO NOT want a "DO NOT RESUSCITATE" order. _______ *Initial*

______________________________ Date ____/____/____
Patient or Legally Authorized Representative Signature

If signed by patient representative, complete the following:

______________________________ ______________ ( ) ______________
Print Name *Relationship* *Phone*

____
Patient Street Address, City, State, ZIP

______________________________ Date ____/____/____
Care Manager Signature/Title

DNR PHYSICIAN ORDERS

This directive is the expressed wish of the above patient.

❑ DO NOT RESUSCITATE. In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated.

______________________________ ______________ Date ____/____/____
Physician's Signature *Phone*

Part 1 – To Physician (For Signature) Part 2 – Patient Part 3 – Clinical Record (Temporary Copy)

PATIENT NAME - Last, First, Middle Initial	ID#

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