

DNR ORDER REQUEST
(DO NOT RESUSCITATE)

I, _____, hereby request a DNR (do not resuscitate) order.
(print patient's name)

I have discussed this request with my physician, _____ (physician's name) and declare that I make this request with informed consent, having been apprised of the details, risks, and benefits of a do not resuscitate order ("DNR order") by such physician.

In the event that I require resuscitation (if my heart stops beating and/or if I stop breathing), I hereby authorize emergency medical personnel to withhold all emergency or medical procedures necessary to resuscitate me or prolong my life, including but not limited to procedures intended to restart my respiration or heartbeat, and let me die naturally.

This DNR order request will not prevent my treatment for other emergency medical conditions by emergency medical care personnel, first responders, and/or emergency medical care directed by a physician, nor will it prevent me from receiving other emergency treatment such as oxygen, intravenous fluids, and the administration of medications with the purpose of relieving pain.

I may revoke this request at any time by destroying this form and removing any "DNR" medallions affixed to this form, or by executing a written revocation of this form.

I give permission for this information to be given to any emergency medical personnel, first responders, emergency care doctors, nurses or other medical providers as necessary to implement this request.

I hereby affirm my request and agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate/Health Care Agent Signature

Date

Surrogate/Health Care Agent's Relationship to Patient

If a health care surrogate or agent signs this form, the surrogate or agent acknowledges that this DNR request comports with the wishes of the principal and is in the principal's best interest.

(witness signatures follow on next page)



Signatures of Witnesses:

First Witness

_____ Print name
_____ Address
_____ City, State
_____ Signature
_____ Date

Second Witness

_____ Print name
_____ Address
_____ City, State
_____ Signature
_____ Date



PHYSICIAN APPROVAL OF DNR REQUEST
AND
DNR ORDER

I, _____ (physician's name), declare that the patient/surrogate/health care agent who signed the DNR ("do not resuscitate") request attached to this form has been informed of the risks and benefits of the DNR request, and has given his/her informed consent to a DNR order.

I further declare that this DNR order is consistent with the expressed wishes of the patient, or his/her surrogate/health care agent if the patient is unable to communicate his/her wishes.

I further declare that a copy of this form is in the patient's permanent medical record.

Therefore, I order that, in the event of cardiac or respiratory arrest, emergency medical personnel shall withhold all emergency or medical procedures necessary to resuscitate the patient, including, but not limited to, intubation, chest compressions, artificial ventilation, defibrillation, or any medications with resuscitative functions.

Physician Signature

Date

Print Name

Telephone

