COLORADO DIRECTIVE

Patient or Authorized Agent’s Directive
to withhold
Cardiopulmonary Resuscitation (CPR)
State of Colorado

Patient’s Name: ____________________________
(Printed name)

Name of: Agent/legally authorized guardian/parent of minor child (if applicable): ____________________________
(Printed name)

Date of Birth: ___ / ___ / ___
Gender: □ Male □ Female
Eye Color: _____________ Hair Color: _____________

Race/Ethnicity: □ Asian or Pacific Islander
□ Black, non-Hispanic □ White, non-Hispanic
□ American Indian or Alaska Native □ Hispanic □ Other

Name of hospice program (if applicable): ___________________________________________________________

Attending Physician’s Name: ________________________________

Physician’s Address: _______________________________________

Physician’s telephone: (______) ________________
Physician’s License #: ______________________

Directive made on this date: __________, pursuant to Colorado Revised Statute 15-18.6-101.
(Month, day, year)

Check only one of the following (as appropriate):

□ Patient: I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf, and I have been advised that the expected result of executing this directive is my death, in the event that my heart or breathing stops or malfunctions.

□ Authorized Agent/legally authorized guardian/parent of minor child: I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that the expected result of executing this directive is the death of the patient, in the event the patient’s heart or breathing stops or malfunctions.

I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient’s heart or breathing stops or malfunctions. I understand that this directive does not apply to other medical interventions for comfort care. If I/the patient am/is admitted to a health care facility, this directive shall be implemented as a physician’s order, pending further physician’s orders.

Use of original signatures on each page of this form makes each page an original document.

Signature of □ Patient or □ Authorized Agent/legally authorized guardian/parent of minor child

Signature of Attending Physician

I hereby make an anatomical gift, to be effective upon my death of: □ Any needed tissues. □ The following tissues:
□ Skin □ Cornea □ Bone, related tissues and tendons. Donor Signature: _______________________________

These tissue donations do not require resuscitation

This form is a CPR Directive authorized by the Colorado General Assembly.
The CPR program is being administered by the Colorado Department of Public Health & Environment.

CPR directive forms administered by the CDPHE contain the blue “CPR” design in the background and the Colorado Directive logo.

White/Gold - Patient/Agent (DeclaratANT) Yellow - Patient’s Medical Record Pink - Bracelet/Necklace Supplier