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 CDPH&E contain the blue "CPR" design in the background and the Colorado Directive logo.

WHITE/GOLD - PATIENT/AGENT (DECLARANT) YELLOW- Patient's MEDICAL RECORD PINK - BRACELET/NECKLACE SUPPLIER