MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

CCFORM_INSERT
2/2007

COMFORT CARE / DO NOT RESUSCITATE (“DNR”) ORDER VERIFICATION

PATIENT’S LAST NAME	
PATIENT’S FIRST NAME	PATIENT’S MIDDLE NAME OR INITIAL
DATE OF BIRTH (MM/DD/YYYY)	GENDER ☐ M ☐ F

STREET OR RESIDENTIAL ADDRESS		
CITY	STATE	ZIP CODE (5 or 9 digits) _

LAST NAME OF GUARDIAN OR HEALTH CARE AGENT (If applicable)	
FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT	MIDDLE NAME OR INITIAL

PATIENT/GUARDIAN/HHEALTH CARE AGENT STATEMENT (SIGNATURE AND DATE REQUIRED)

I ______________________________ (☐patient ☐ guardian ☐health care agent) verify that the above named patient has a current and valid Do Not Resuscitate order (“DNR order”). I understand that by signing this form, the DNR order, if current and valid, will be recognized in out-of-hospital settings and the COMFORT CARE / Do Not Resuscitate Order Verification Protocol will be followed by emergency medical services personnel.

Signature of Patient/Guardian/Health Care Agent ______________________ Date ____________

PHYSICIAN / NURSE PRACTICIONER (NP) / PHYSICIAN ASSISTANT (PA) VERIFICATION (PHYSICIAN / NP / PA SIGNATURE AND DATES ALWAYS REQUIRED)

I am an attending physician / NP / PA for the above named patient. I verify that the above named patient has a current and valid Do Not Resuscitate order, issued on ____________________

This DNR order ☐ does ☐ does not have an expiration date. If there is an expiration date, it is indicated below, and this verification form also expires on that date.

I hereby direct that all emergency medical services personnel comply with the Massachusetts Department of Public Health, Office of Emergency Medical Services’ COMFORT CARE / Do Not Resuscitate Order Verification Protocol with regard to the above named patient.

Signature of Physician / NP / PA

Print Name of Physician / NP / PA	Effective Date of CC / DNR Order Verification	Expiration Date (if any) of DNR Order and CC/DNR Order Verification
Address of Physician / NP / PA		
Telephone Number of Physician / NP / PA		

OPTIONAL BRACELET INSERTS

Attention Physician/NP/PA	
Attention Physician/NP/PA If used, enter information or print legibly. Physician/NP/ PA must sign, tear off strip, fold, trim, and insert in bracelet. **Massachusetts** **Comfort Care/DNR Order Verification**	Pat. Name ________ Gender M ☐ F☐ Pat. DOB: ______ Expir. Date: ______ Tel. _ – _ – _ MD/NP/PA ________ Signature ________
Attention Physician/NP/PA If used, enter information or print legibly. Physician/NP/ PA must sign, tear off strip, fold, trim, and insert in bracelet. **Massachusetts** **Comfort Care/DNR Order Verification**	Pat. Name ________ Gender M ☐ F☐ Pat. DOB: ______ Expir. Date: ______ Tel. _ – _ – _ MD/NP/PA ________ Signature ________
Attention Physician/NP/PA If used, enter information or print legibly. Physician/NP/ PA must sign, tear off strip, fold, trim, and insert in bracelet. **Massachusetts** **Comfort Care/DNR Order Verification**	Pat. Name ________ Gender M ☐ F☐ Pat. DOB: ______ Expir. Date: ______ Tel. _ – _ – _ MD/NP/PA ________ Signature ________
Attention Physician/NP/PA If used, enter information or print legibly. Physician/NP/ PA must sign, tear off strip, fold, trim, and insert in bracelet. **Massachusetts** **Comfort Care/DNR Order Verification**	Pat. Name ________ Gender M ☐ F☐ Pat. DOB: ______ Expir. Date: ______ Tel. _ – _ – _ MD/NP/PA ________ Signature ________