Do Not Resuscitate Order

Patient Name: _____

Date: _____

I am: ☐ The Patient ☐ Surrogate ☐ Proxy ☐ Power of Attorney

I, being fully informed that a DNR means that resuscitative procedures will not be performed in the event of cardiac or respiratory arrest, hereby request that CPR be withdrawn or withheld from the Patient named above. I understand that in these instances only limited emergency care will be provided.

_____ _____

Patient Name Date

Physician Name: _____

Clinic/Hospital: _____

Date: _____

I, the Physician, recognize that the Patient or his/her proxy has made an informed decision in executing this directive. A copy of this DNR order will be kept in the Patient's permanent medical file.

In the event of cardiac or respiratory arrest no intubation, defibrillations, chest compressions, assisted breaths, or cardiotonic medications will be administered to the Patient.

_____ _____

Physician Name Date