DO NOT RESUSCITATE ORDER

State of Florida, Section 401.45, Florida Statutes

PATIENT'S OR AUTHORIZED PERSON'S STATEMENT

I, ______________________________, ________________,
(Print or Type Full Legal Name) (Date of Birth)

being informed of my right to refuse cardiopulmonary resuscitation (CPR), including artificial ventilation, cardiac compression, endotracheal intubation, and defibrillation, direct that CPR be withheld or withdrawn from me.

By: ______________________________ Date: ________________
(Signature of Patient or Authorized Person)

I, ______________________________, am authorized to sign on the patient's behalf
(Print or Type Name of Authorized Person)

as the patient's ☐surrogate, ☐proxy, or ☐minor patient's principal (per s. 765.101, F.S.); or I am expressly authorized to make the patient's health care decisions under a ☐guardianship (per s. 744.102, F.S.), or ☐power of attorney (per s. 709.2102, F.S.).

HEALTH CARE PROVIDER'S STATEMENT

I, ______________________________, license number ____________________,
(Print or Type Full Legal Name)

am the patient's ☐ physician, ☐ osteopathic physician, ☐ autonomous practice registered nurse, or ☐ physician assistant authorized by law to sign this order. I direct the withholding or withdrawal of CPR from the patient in the event of the patient's cardiac or respiratory arrest.

By: ______________________________ Date: ________________ Ph: ____________
(Signature of Health Care Provider) (Emergency No.)

A copy of this order reproduced on yellow paper (any shade) is valid as the original.

Cut along line and fold in half to create DNRO Device (wallet card).

PATIENT'S OR AUTHORIZED PERSON'S STATEMENT

I, __________________________, ______________,
(Print or Type Full Legal Name) (Date of Birth)

being informed of my right to refuse cardiopulmonary resuscitation (CPR), including artificial ventilation, cardiac compression, endotracheal intubation, and defibrillation, direct that CPR be withheld or withdrawn from me.

By: ______________________ Date: ______________
(Signature of Patient or Authorized Person)

I, ________________________, am authorized to sign on
(Print or Type Name of Authorized Person)

the patient's behalf as the patient's ☐surrogate, ☐proxy, or ☐minor patient's principal (per s. 765.101, F.S.); or I am expressly authorized to make the patient's health care decisions under a ☐guardianship (per s. 744.102, F.S.), or ☐power of attorney (per s. 709.2102, F.S.).

HEALTH CARE PROVIDER'S STATEMENT

I, ______________________________,
(Print or Type Full Legal Name)

license number ____________________,

am the patient's ☐ physician, ☐ osteopathic physician, ☐ autonomous practice registered nurse, or ☐ physician assistant authorized by law to sign this order. I direct the withholding or withdrawal of CPR from the patient in the event of the patient's cardiac or respiratory arrest.

By: ______________________________
(Signature of Health Care Provider)

Date: ________________

Ph: ______________
(Emergency No.)

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