KHOBCARE LLC HOME HEALTHCARE

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

Patient Directive

I, _____, born on _____, hereby direct the following in the event of:
(print full name) (birth date)

1. FULL CARDIOPULMONARY ARREST (When both breathing and heartbeat stop):

❑ **Do Not Attempt Cardiopulmonary Resuscitation (CPR)**
(Measures to promote patient comfort and dignity will be provided.)

2. PRE-ARREST EMERGENCY (When breathing is labored or stopped, and heart is still beating):

SELECT ONE

❑ **Do Attempt Cardiopulmonary Resuscitation (CPR) -OR-**

❑ **Do Not Attempt Cardiopulmonary Resuscitation (CPR)**
(Measures to promote patient comfort and dignity will be provided.)

Other Instructions _____

_____

Patient Directive Authorization and Consent to DNR Order (Required to be a valid DNR Order)

I understand and authorize the above Patient Directive, and consent to a physician DNR Order implementing this Patient Directive.

_____	_____	_____
Printed name of individual	Signature of individual	Date

-OR-

_____	_____	_____
Printed name of (circle appropriate title): legal guardian OR agent under health care power of attorney OR healthcare surrogate decision maker	Signature of legal representative	Date

Witness to Consent (Required to have two witnesses to be a valid DNR Order)

I am 18 years of age or older and have witnessed the giving of consent by the above person.

_____	_____	_____
Printed name of witness	Signature of witness	Date

_____	_____	_____
Printed name of witness	Signature of witness	Date

Physician Signature Required to seal DNR request

I hereby execute this DNR Order on _____.
Today's date

_____	_____	_____
Signature of attending physician	Printed Name of attending physician	Physician's telephone number

◆ *Send this form or a copy of both sides with the individual upon transfer via emergency response.*

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Patient's name _____

Summarize medical condition:

When This Form Should Be Reviewed

This DNR order, in effect until revoked, should be reviewed periodically, particularly if –

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

How to Complete the Form Review

1. Review the other side of this form.
2. Complete the following section.
   If this form is to be voided, write "VOID" in large letters on the other side of the form.
   After voiding the form, a new form may be completed.

Date	Reviewer	Location of review	Outcome of Review
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; **no** new form completed
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; **no** new form completed
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; **no** new form completed

Advance Directives

I also have the following advance directives:

Contact person (name and phone number)

- ❑ Health Care Power of Attorney _____
- ❑ Living Will _____
- ❑ Mental Health Treatment Preference Declaration _____

◆ *Send this form or a copy of both sides with the individual upon transfer or discharge.* ◆