ADVANCE DIRECTIVE

Resident's Name ***Date of Birth***

Person with legal capacity to make this decision: _____

(Please Print)

☐ *RESIDENT* ☐ *POA* ☐ *SPOUSE* ☐ *OTHER*

The resident identified above has consented to the following plan:

☐ **FULL RESUSCITIVE MEASURES**	**Emergency** *measures will be taken to sustain and prolong life. Cardiopulmonary Resuscitation (CPR) in the event of Cardiac Pulmonary Arrest. Hospital admission may be necessary.*
☐ **LIVING WILL**	**CPR will be performed and Paramedic called. Upon arrival to a hospital,** *family will discuss further heroic actions.*
☐ **DO NOT RESUSCITATE (DNR)**	**In the event of cardiopulmonary arrest there will be NO** *resuscitation effort allowed. Therapeutic care will be provided for any* ***OTHER*** *medical conditions including Emergency Room treatment and/or hospitalization.*

RESIDENT, FAMILY, OR POA

As the undersigned, I attest that I have been informed of and understand the care and treatment option offered at this facility. I understand that I may revoke this directive at any time. I give permission for this information to be given to Physicians, Nurses, Paramedics, and other health personnel as necessary to implement this directive.

Signature	*Relationship to Resident*	*Date Signed*

ATTENDING PHYSICIAN

This directive is the expressed wish by the resident, guardian, and/or family. Medically appropriate and documented in the resident's medical records.

Signature	*Relationship to Resident*	*Date Signed*

FACILITY REPRESENTATIVE

Signature	*Relationship to Resident*	*Date Signed*