

DO NOT RESUSCITATE ORDER

1. CONSENT

I, _____ *[patient name]*, a resident of _____
[patient's hospital or facility address], individually or through my legally authorized representative,
being of sound mind and legal age, hereby request and consent to emergency medical treatment only as
set forth herein.

I understand and acknowledge that a Do Not Resuscitate Order means that, in the event that my heart
stops beating or I stop breathing, no medical treatments or procedures shall be started or continued by
the staff of this Facility. Furthermore, I give permission and hereby consent to this information being
provided to paramedics, doctors, nurses, hospital personnel, or any other health care or emergency
personnel. I understand and acknowledge that this decision may not prevent emergency medical
treatment by paramedics or other medical or emergency personnel prior to my death.

I, _____ *[physician name]*, am the attending physician of the patient
named above and direct all medical personnel not to initiate any medical treatments or
cardiopulmonary procedures to resuscitate the patient.

2. EFFECTIVENESS AND REVOCATION

This Do Not Resuscitate Order shall take effect on _____ *[date of*
signing] and shall continue to be effective until _____ *[effectiveness*
end date].

3. PATIENT AND PHYSICIAN SIGNATURES

Patient Name

Physician Name

Patient Signature

Physician Signature

Date: _____

Date: _____

4. WITNESS ATTESTATION

The above patient executing this order appears to be of sound mind and under no duress, fraud, or undue influence. I attest that I am of sound mind and legal age and that I have witnessed the giving of consent by the above Declarant.

First Witness Name: _____

Second Witness Name: _____

(First Witness Signature)

(Second Witness Signature)