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: _____

_____

(First Witness Signature)

Second Witness Name: _____

_____

(Second Witness Signature)