**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.

1. **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]*.

1. **PATIENT AND PHYSICIAN SIGNATURES**

| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Patient Name*  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Physician Name* |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Patient Signature* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Physician Signature* |
| Date: \_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_ |

1. **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)* |