DO NOT RESUSCITATE ORDER REQUEST FORM

DECISION TO LIMIT THE SCOPE OF EMERGENCYMEDICAL CARE

I, (patient) _____, (DOB) _____, request limited emergency care for me as described below.

If my heart stops beating or if I stop breathing, no medical procedures to restart breathing or heart functioning will be instituted. No resuscitation will be attempted.

- I understand that the procedure I am refusing, known as cardiopulmonary resuscitation (CPR), includes chest compressions, assisted ventilations, intubation, defibrillation, administration of cardiotonic medications and other related medical procedures.
- I do not intend for this decision to prevent me from obtaining emergency or other medical care, especially comfort measures and pain medication, directed by a physician prior to my death.
- I understand that I may revoke this directive at any time.
- I give permission for this information to be given to emergency care providers, doctors, nurses or other health care personnel.
- This DNR form shall remain in effect while I am admitted at a medical care facility or care home as well as during transport to or from a home for facility.
- I do hereby agree to the Do Not Resuscitated (DNR) and request an entry of a DNR Order. I intend for this to be my direction to my physician(s), other healthcare providers, my family and all others.

Patient Signature: _____ Date:_____

Witness Signature: _____ Date:_____

Should Durable Power of Attorney of Health Care Decisions be in effect, the DPOA is agreeing and consenting to the wishes of a DNR with much consideration of the patient's best interest in mind:

DPOA Signature: _____ Date:_____

Witness Signature: _____ Date:_____

Attending Physician Order: I affirm this directive is the expressed wish of the patient, is medically appropriate and is documented in the patients permanent medical record. **In the event of a acute cardiac or respiratory arrest, no cardiopulmonary resuscitation shall be attempted. This is a DNR ORDER.**

Signature: _____ Date: _____

Revocation Provision: I hereby withdraw the above declaration.

Signature: _____ Date: _____

HUTCHINSON
REGIONAL HEALTHCARE SYSTEM