

DO NOT RESUSCITATE ORDER
FOR

ATTENTION! DO NOT ATTEMPT TO RESUSCITATE THIS PATIENT!

This document is an official request, legal in the state of STATE, to order all medical personnel to cease any attempt to resuscitate this patient and allow natural death. (Sections I, II, III, or IV should be completed along with section V.)

I. PATIENT'S REQUEST

I, _____ the undersigned patient, hereby direct to withhold any resuscitative measures to be conducted on me in the event of cardiopulmonary cessation. I have consulted and discussed this decision with my physician, and I understand the consequences of such a decision.

Signature of the Patient _____

Date _____

II. ADVANCE DIRECTIVE/LIVING WILL

I, _____ an authorized representative of _____ hospital, hereby attest that the patient no longer or is able to understand, appreciate, or respond to any medical treatment directed to them, with no hope of regaining that ability. I, therefore, agree to follow a duly executed living will or advance directive with healthcare instructions indicating that no resuscitative or life-sustaining treatment and measure should be provided or attempted was authorized by the patient and has been made part of their medical records.

Signature of the Representative _____ Date _____

III. MEDICAL POWER OF ATTORNEY/AGENT/ATTORNEY-IN-FACT'S CONSENT

I, _____, the Agent/Attorney-in-Fact for the Patient, appointed in a duly executed Medical Power of Attorney or equivalent document, reserve the right to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment for the Patient. Therefore, I hereby direct that resuscitative measures be withheld from the Patient in the event of cardiopulmonary cessation. A copy of the Agent/Attorney-in-Fact appointment (e.g. living will, power of attorney, advance directive, etc.) has been attached and made part of the Patient's medical record.

Signature of the Agent/Attorney-in-Fact _____ Date _____

IV. SURROGATE'S CONSENT

I, _____, the Surrogate, is authorized to make decisions in the consultation with the attending physician with regards to the providing, withholding, withdrawal of life-sustaining treatment for the Patient. Upon consulting with the attending physician, I hereby direct that all resuscitative measures be withheld from the Patient in the event of cardiopulmonary cessation. I believe that this decision conforms as closely as possible to what the Patient would have wanted. I make this decision in good faith and without consideration of the financial benefit or burden which may accrue to me or to the health care

provider as a result of this decision. A copy of the Health Care Surrogate Designation has been attached and made part of the Patient's Medical Record.

Signature of Surrogate _____ Date _____

V. *PHYSICIAN'S AUTHORIZATION

Based on the aforementioned information, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold all and any resuscitative measures: cardiopulmonary resuscitation, chest compression, endotracheal intubation, and other advanced airway management, artificial ventilation, cardiac resuscitative medications, and cardiac defibrillation, in the event of cardiopulmonary cessation in the Patient. I further direct the implementation of all reasonable comfort care such as oxygen, suction, control of bleeding, administration of pain medication by all and any person so authorized, and other therapies to provide comfort and alleviate suffering by the Patient; and to provide support to the Patient, family members, friends, and others present.

Signature of Physician _____
Print Name _____
Date _____

VI. WITNESS(ES) AND/OR NOTARY PUBLIC

I/We, the undersigned witness(es), hereby declare that all signing parties to this document were of sound mind, and under no duress, fraud, or undue influence. In addition, I/We hereby attest to have witnessed their signatures and have no monetary gain from the authorization of this form, including but not limited to, being made part of the Patient's estate or of a relative that is part of the Patient's estate.

Signature of Witness #1 _____
Print Name _____
Date _____

Signature of Witness #2 _____
Print Name _____
Date _____

NOTARY ACKNOWLEDGMENT

The State of _____ .

County of _____

On this day _____ , The foregoing instrument was acknowledged before me by _____ . This foregoing instrument was executed and acknowledged as his/her free act and deed, under no duress, fraud, or undue influence from any parties.

Notary Public

Notes: *Physician's authorization is required in all 50 States except Kentucky.

***The following States have additional signature requirements (alphabetical): Arizona(one (1) additional witness), Illinois(one (1) additional witness), Indiana(two (2) additional witnesses), Kansas(one (1) additional witness), Kentucky(two (2) additional witnesses or a notary public), Nebraska(one (1) additional witness), Oklahoma(two (2) additional witnesses), and Texas(two (2) additional witnesses or a second (2nd) physician)**