

Pre-Hospital DNR (Do Not Resuscitate) Request Form

An Advanced Request to Limit the Scope of Emergency Medical Care

I, _____, Date of Birth _____, request limited emergency care as herein described.

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will *not* prevent me from obtaining other emergency medical care by pre-hospital care providers or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time.

I give permission for this information to be given to the pre-hospital care providers, doctors, nurses, or other health care personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) directive.

Signature*

Date

Witness**

Date

* May be signed by another person in the declarant's presence and by the declarant's expressed direction.

** Witness must be at least 18 years of age and shall not be the person who signed the declaration on behalf of and at the direction of the person making the declaration, related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant, or directly financially responsible for the declarant's medical care.

I AFFIRM THIS DIRECTIVE IS THE EXPRESSED WISH OF THE PATIENT, IS MEDICALLY APPROPRIATE, AND IS DOCUMENTED IN THE PATIENT'S PERMANENT MEDICAL RECORD.

In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated.

Attending Physician's Signature***

Date

Address

Facility or Agency Name

*** Signature of physician not required if the above-named is a member of a church or religion which, in lieu of medical care and treatment, provides treatment by spiritual means through prayer alone and care consistent therewith in accordance with the tenets and practices of such church or religion.

REVOCATION PROVISION

I hereby revoke the above declaration.

Signature

Date

Discuss this document and your treatment preferences with your physician(s), family members, and designated agent, and provide them with a signed copy or photocopy.