DO NOT RESUSCITATE ORDER FOR

_____

ATTENTION! Please do not attempt to resuscitate this patient!

This document constitutes the formal instruction/request, legal in the State of _____, to mandate all medical personnel to cease all efforts to resuscitate the Patient and allow a natural death. Sections I, II, III, or IV must be completed along with Section V.

Section I. Patient Request

I, _____, the patient undersigned, orders that, if cardiopulmonary cessation occurs, resuscitative measures must not be administered to me. My doctor and I have discussed about this choice, and we both agree that I am aware of the implications.

Signature of Patient _____ Date _____

Section II. Advance Directive/Living Will

I, _____, an Authorized Representative of _____ [Hospital/Medical Facility], attest that the Patient is no longer competent or able to understand, appreciate, or direct the medical treatment they receive. In view of these circumstances, I hereby consent to following a duly executed Advance Directive/Living Will that specifies that no life-sustaining treatment should be provided, which has been approved by the Patient and made part of their medical record.

Signature of Representative _____ Date _____

Section III. Medical Power of Attorney – Agent/Attorney-in-Fact Consent

In accordance with a duly executed Medical Power of Attorney or equivalent document, I, _____, as Agent/Attorney-in-Fact for the Patient, reserve the right to provide, withhold, or withdraw life-sustaining treatment to the Patient. Accordingly, I direct withholding of resuscitative measures in the event of cardiopulmonary arrest for the Patient. Patient's medical record includes a copy of the Agent/Attorney-in-Fact designation (e.g., living will, power of attorney, advance directive, etc.).

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

Section IV. Surrogate Consent

In consultation with the attending physician, I, _____, am certified to make decisions regarding the provision, withholding, and withdrawal of life-sustaining treatment for the patient. In the event of cardiopulmonary cessation, I direct that resuscitative measures not be administered to the Patient. It is my belief that this decision conforms to what the Patient would have wanted. This decision is made in good faith and without considering any financial benefits or burdens that may accrue to me or to the health care provider. The Health Care Surrogate Designation has been attached and made a part of the Patient's Medical Record.

Signature of Surrogate _____ Date _____

V. *Physician Authorization

In light of the aforementioned information, I would like to direct all medical personnel, emergency responders, and paramedical personnel to refrain from resuscitative measures. In the event of cardiopulmonary cessation in the Patient, cardiopulmonary resuscitation, chest compression, endotracheal intubation and other advanced airway management, artificial ventilation, cardiac resuscitative mediations, and cardiac defibrillation should be performed.

For the Patient's comfort and alleviation of suffering, I direct the implementation of all reasonable comfort care measures such as oxygen, suction, bleeding control, pain medication administration by authorized personnel, and other therapies. Additionally, I assist the Patient, family members, friends, and others present with their needs.

Signature of Physician _____ Date _____

Print Name _____

The authorization of a physician is required by all 50 states except Kentucky.

VI. *Witness(es) and/or Notary Public

In this document, I/we, the undersigned Witness(es), declare that all parties were of sound mind and not subjected to duress, fraud, or undue influence. Also, I attest that I witnessed their signatures and have no monetary gain from authorizing this form, including but not limited to being added to the Patient's estate or that of a relative.

Signature of Witness #1 _____ Date _____

Print Name _____

Signature of Witness #2 _____ Date _____

Print Name _____

- -

Notary Acknowledgment

State of _____

County of _____

This ____ day of _____, 20____, by _____ (name

of person acknowledged), I acknowledge the foregoing instrument.

_____

(Signature of Acknowledger)

(Title or Rank): _____

(Serial Number, if any): _____

*The following States (alphabetical) have additional signature requirements: 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), Texas (two (2) additional witnesses or a second (2nd) physician).