

OUTSIDE THE HOSPITAL DNR REQUEST FORM

An Advanced Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(name)

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 and/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 personnel as necessary to implement this directive.

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

Patient/Appropriate Surrogate Signature

Date

Witness

Date

REVOCATION PROVISION

I hereby revoke the above declaration.

Signature

Date

I AFFIRM THIS DIRECTIVE IS THE EXPRESSED WISH OF THE PATIENT/PATIENT'S APPROPRIATE SURROGATE, 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.

Physician's Signature

Date

Address

Facility or Agency Name

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY.

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