DNR
DO-NOT-RESUSCITATE DIRECTIVE
K.S.A. 65-4941, ET. SEQ.

DECISION TO LIMIT EMERGENCY MEDICAL CARE

I, (Your name)____________________________________, request that effective today, emergency care for me will be limited 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 other medical care, especially comfort measures and pain medication.

• I understand 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 directive 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 or facility.

X ____________________________  ____________________________
(Signature)  (Date)

X ____________________________  ____________________________
(Witness signature)  (Date)

Attending Physician Order: I have discussed the use of cardiopulmonary resuscitation with this patient and recognize the patient’s decision to refuse CPR.
• In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation shall be attempted. DNR

X ____________________________  ____________________________
(Attending Physician’s Signature)  (Date)

______________________________  ____________________________
(Address)  (Facility, Clinic or Hospital Name)

Revocation: I hereby withdraw the above DNR directive.

X ____________________________  ____________________________
(Signature)  (Date)