DO NOT RESUSCITATE ORDER FOR

_____

ATTENTION! DO NOT MAKE ANY ATTEMPT TO RESUSCITATE THIS PATIENT!

This document represents the official request, legal in the State of _____, to order all medical personnel to cease any attempt to resuscitate the Patient and allow a natural death. Section I, II, III, or IV must be completed along with Section V.

I. Patient Request

I, _____, the undersigned Patient, direct that resuscitative measures be withheld from me in the event of cardiopulmonary cessation. I have discussed this decision with my physician, and I understand the consequences of this decision.

Signature of Patient _____ Date _____

Section II. Advance Directive/Living Will

I, _____, an Authorized Representative of _____ [Hospital/Medical Facility], hereby attest the Patient is no longer competent or able to understand, appreciate, and direct their medical treatment with no hope of regaining that ability. Therefore, I agree to follow a duly executed Advance Directive/Living Will with health care instructions specifying that no life-sustaining treatment be provided was previously authorized by the Patient and has been made part of their medical record.

Signature of Representative _____ Date _____

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

I, _____, the Agent/Attorney-in-Fact for the Patient as designated by 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 designation (e.g. living will, power of attorney, advance directive, etc.) has been attached and made part of the Patient's medical record.

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

Section IV. Surrogate Consent

I, _____, the Surrogate certified to make decisions in consultation with the attending physician, regarding the providing, withholding, withdrawal of life-sustaining treatment for the Patient. After consultation with the attending physician, I hereby direct that 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 Authorization

Based on the aforementioned information, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold resuscitative measures i.e. cardiopulmonary resuscitation, chest compression, endotracheal intubation and other advanced airway management, artificial ventilation, cardiac resuscitative mediations, 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 personnel 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 _____ Date _____

Print Name _____

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

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

I/We, the undersigned Witness(es), declare that all signing parties to this document were of sound mind, and under no duress, fraud, or undue influence. In addition, I 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 _____ Date _____

Print Name _____

Signature of Witness #2 _____ Date _____

Print Name _____

- -

Notary Acknowledgment

State of _____

County of _____

The foregoing instrument was acknowledged before me this ____ day of

_____, 20____, by _____ (name of person

acknowledged).

_____

(Signature of Person Taking Acknowledgment)

(Title or Rank): _____

(Serial Number, if any): _____

*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)