

# Patient's or Authorized Agent's Directive to Withhold Cardiopulmonary Resuscitation (CPR)

This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

## Patient's Information

Patient's Name \_\_\_\_\_  
(Printed Name)

If Applicable- Name of Agent/Legally Authorized Guardian/Parent of Minor Child \_\_\_\_\_  
(Printed Name)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Race Ethnicity :  Asian or Pacific Islander  Black, non-Hispanic  White, non-Hispanic  
 American Indian or Alaska Native  Hispanic  Other

If Applicable- Name of hospice program/provider: \_\_\_\_\_

## Physician's Information

Physician's Name: \_\_\_\_\_  
(Printed Name)

Physician's Address: \_\_\_\_\_

Physician's telephone: ( ) \_\_\_\_\_ Physician's Colorado License #: \_\_\_\_\_

## Directive Attestation

Check **ONLY** the information that applies:

- Patient:** I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.
- Authorized Agent/Legally Authorized Guardian/Parent of Minor Child:** I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient's heart or breathing stops or malfunctions, the patient will not receive CPR and may die.
- Tissue Donation:** I hereby make an anatomical gift, to be effective upon my death of:  
 Any needed tissues  
The following tissues:  Skin  Cornea  Bone, related tissues and tendons

**I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient's care and comfort. If I/the patient am/is admitted to a health care facility, this directive shall be implemented as a physician's order, pending further physician's orders.**

\_\_\_\_\_  
 Signature of Patient  
 Authorized Agent/Legally Authorized Guardian/Parent of Minor Child

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date