

Authorized Durable Do Not Resuscitate Order Form & Instructions

Purpose

The Durable Do Not Resuscitate (DDNR) Order and its regulations have been developed to carry out the intent of applicable Virginia law that provides a person the opportunity to execute a DDNR Order that comports with his/her wishes.

Applicability

The DDNR form may be honored by any "qualified health care personnel," which is defined as any qualified emergency medical services personnel and any licensed healthcare provider or practitioner functioning in any facility, program or organization operated or licensed by the State Board of Health, or by the Department of Mental Health, Mental Retardation and Substance Abuse Services or operated, licensed or owned by another state agency, or a licensed health care practitioner at any continuing care retirement community.

Instructions

12VAC5-66-70. Issuance of a Durable DNR Order Form or Other DNR Order.

A Durable DNR Order Form or Other DNR Order may be issued to a patient by a physician, with whom the patient has established a bona fide physician/patient relationship, only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf.

1. The use of the Virginia Department of Health's Office of Emergency Medical Services (VDH/OEMS) authorized Durable DNR Order Form is encouraged to provide uniformity throughout the health care continuum.
2. The authorized Durable DNR Order Form can be honored by qualified health care personnel in any setting.
3. Patients that are not within a qualified health care facility or receiving hospice or health care services at home must have an authorized Durable DNR Order Form (State Form) or alternate DDNR jewelry in order for the DDNR Order to be honored.
4. Other DNR Orders can be honored any time when a patient is within a qualified health care facility, during transfer between qualified health care facilities when the patient remains attended by qualified health care personnel or receiving hospice or health care services at home.
5. The physician shall explain to the patient or the person authorized to consent on the patient's behalf, the alternatives available for response in the event of cardiac or respiratory arrest. If the option of a Durable DNR Order is agreed upon, the physician shall have the following responsibilities:
 - a. Explain when the Durable DNR Order can be followed.
 - b. Explain how to and who may revoke the Durable DNR.
 - c. Document the patient's full legal name.
 - d. Document the execution date of the Durable DNR Order.
 - e. Obtain the signature of the patient or the person authorized to consent on the patient's behalf on all three forms; the patients copy, medical record copy, and the copy used for obtaining DNR Jewelry.

- f. The physician name should be clearly printed and the form signed.
- g. Note the contact telephone number for the issuing physician.
- h. Issue the original Durable DNR Order Form; Copy 1 is to be kept by the patient, Copy 2 is to be placed in the patient's medical record, and Copy 3 is kept by the patient to order DDNR Jewelry. All three copies may be honored by qualified health care personnel whether it is an original or photocopy.
- i. The person to whom a Durable DNR order applies or the person authorized to consent on the patient's behalf must present the following information to the approved vendor in order to purchase and be issued an approved Alternate Durable DNR necklace or bracelet. The necklace or bracelet must contain the following information:
 - i. The following words: Do Not Resuscitate;
 - ii. The patient's full legal name;
 - iii. The physician's name and phone number; and
 - iv. The Virginia Durable DNR issuance date.

Revocation

Revocation of a Durable DNR Order - A Durable DNR Order may be revoked at any time by the patient or an authorized decision maker if the decision maker initiated the DDNR Order (i) by physically destroying the Durable DNR Order Form or having another person in his/her presence and at his/her direction destroy the Durable DNR Order Form and/or any alternate form of identification; or (ii) by oral expression of intent to revoke. If an Other DNR Order exists and is revoked, health care personnel should assure the revocation is honored by updating or destroying the Other DNR Order.

Signature of the Patient

The patient shall be informed that they are signing that they direct that in case of cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation will not be initiated and not be continued once initiated. They shall understand that they may revoke these directions at any time by physical cancellation or destruction of this form or by orally expressing a desire to be resuscitated to qualified health care personnel. They shall also understand that if qualified health care personnel have any doubts about the applicability or validity of this order, they will begin cardiopulmonary resuscitation.

If the patient is a minor or not legally capable of making an informed decision the person authorized to consent on the patient's behalf shall sign that by virtue of their relationship to the patient (i.e. designated agent, guardian or committee, spouse, adult child, parent, adult brother or sister, other relative in descending order of blood relationship.) In this capacity, they direct that in the case of the patient's cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation not be initiated and not be continued once initiated. They shall understand that they may revoke these directions at any time by physical cancellation or destruction of this form or by orally expressing this desire to be resuscitated to qualified health care personnel. They shall also understand that if qualified health care personnel have any doubts about the applicability or validity of this order, they will begin cardiopulmonary resuscitation.

More information can be found on-line at [Durable Do Not Resuscitate Program – Emergency Medical Services](#)



Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ Date _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

- 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)
- 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

- A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.
- B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf" is required.)
- C. The patient has not executed a written advanced directive (living will or durable power of attorney for healthcare). (Signature of "Person Authorized to Consent on the Patient's Behalf" is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

Physician's Printed Name

Physician's Signature

Emergency Phone Number

Patient's Signature

Signature of Person Authorized to Consent on the Patient's Behalf

Copy 1 – To be kept by patient



Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ Date _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

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If you checked 2 above, check A, B, or C below:

- A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.
- B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf" is required.)
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Physician's Printed Name

Physician's Signature

Emergency Phone Number

Patient's Signature

Signature of Person Authorized to Consent on the Patient's Behalf

Copy 2 – To be kept in patient's permanent medical record



Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ Date _____

Physician's Order

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I further certify (must check 1 or 2):

- 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)
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Physician's Printed Name

Physician's Signature

Emergency Phone Number

Patient's Signature

Signature of Person Authorized to Consent on the Patient's Behalf