Outside the Hospital Do- Not- Resuscitate
Identification Card

Patient's Full Name_____

I affirm that I have authorized an Outside the Hospital Do- Not -
Resuscitate Order for this patient and have documented the
grounds for the order in this patient's medical file.

Attending Physician Signature_____

Attending Physician (print)_____

Address_____**Phone**_____

Date_____

I, _____,
(name)
authorize emergency medical services personnel to withhold or
withdraw cardiopulmonary resuscitation from me in the event I
suffer cardiac or respiratory arrest.

I understand this means that if my heart stops beating or I stop
breathing, no medical procedure to restart heart function or
breathing will be instituted.

I understand that I may revoke this order at anytime.
Patient or Patient's Representative
Signature_____
Date_____