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)

We thank Kansas Health Ethics, Inc. (now closed) for their efforts in the development of this and other documents. For more information about obtaining copies of this document contact Wichita Medical Research & Education Foundation, 316-686-7172 or tcarter@wichitamedicalresearch.org,
www.wichitamedicalresearch.org