

# DO NOT RESUSCITATE ORDER

## FOR

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### **CAUTION!: DO NOT MAKE ANY ATTEMPT TO RESUSCITATE THIS PATIENT!**

This document constitutes the formal directive, legally binding in the State of \_\_\_\_\_, instructing all medical personnel to discontinue any efforts to resuscitate the Patient and permit a natural cessation of life. Completion of Sections 1, 2, 3, or 4 along with Section 5 is mandatory.

#### **1. PATIENT REQUEST**

I, [Patient's Name], being of sound mind and understanding the implications of this decision, hereby request that in the event of a cardiac or respiratory arrest, no resuscitative measures be taken. This includes, but is not limited to, cardiopulmonary resuscitation (CPR), defibrillation, intubation, and artificial ventilation.

This decision is made after careful consideration of my medical condition and the likely outcomes of resuscitative efforts. I have discussed this decision with my physician, and I understand the consequences of this directive and accept the risks associated with it.

This order is to be honored by all healthcare providers and emergency personnel involved in my care, regardless of the location or circumstances in which the cardiac or respiratory arrest occurs.

Date: [Date]

Signature: \_\_\_\_\_

#### **2. ADVANCE HEALTHCARE DIRECTIVE/LIVING WILL**

I, \_\_\_\_\_, a Designated Representative of \_\_\_\_\_ [Hospital/Medical Facility], confirm that the Patient is presently incapable of comprehending, acknowledging, and guiding their medical care, with no foreseeable chance of regaining such capacity. Accordingly, I consent to adhere to an appropriately executed Advanced Healthcare Directive/Living Will containing healthcare directives mandating the withholding of life-sustaining

interventions, which was previously endorsed by the Patient and has been integrated into their medical dossier.

### **3. AUTHORIZATION OF DURABLE POWER OF ATTORNEY – AGENT/ATTORNEY-IN-FACT CONSENT**

I, \_\_\_\_\_, acting as the Agent/Attorney-in-Fact for the Patient, as appointed by a validly executed Medical Power of Attorney or equivalent legal document, retain the authority to make determinations regarding the provision, withholding, or cessation of life-sustaining care for the Patient. Consequently, I hereby instruct that resuscitative measures be refrained from in the event of cardiopulmonary arrest. A copy of the Agent/Attorney-in-Fact designation (e.g., living will, power of attorney, advance directive, etc.) has been appended and incorporated into the Patient's medical records.

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

### **4. SURROGATE AUTHORIZATION**

I, \_\_\_\_\_, the Surrogate duly authorized to make decisions in collaboration with the attending physician concerning the provision, withholding, or withdrawal of life-sustaining care for the Patient. Following consultation with the attending physician, I hereby direct that resuscitative measures be abstained from in the event of cardiopulmonary arrest. I firmly believe that this decision aligns closely with the Patient's wishes. I make this determination in good faith and without regard to any financial advantages or burdens that may arise for me or the healthcare provider due to this decision. A copy of the Health Care Surrogate Designation has been appended and incorporated into the Patient's Medical Record.

Surrogate's Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

### **5. . PHYSICIAN AUTHORIZATION**

Given the preceding information, I hereby instruct all medical personnel, emergency responders, and paramedical staff to refrain from employing resuscitative measures, including but not limited to cardiopulmonary resuscitation, chest compressions, endotracheal intubation, advanced airway management, artificial ventilation, cardiac resuscitative medications, and cardiac defibrillation, in the event of cardiopulmonary arrest in the Patient.

I also direct the application of reasonable comfort measures such as oxygen, suctioning, bleeding control, pain relief medication by authorized personnel, and other therapies to offer comfort and alleviate the Patient's distress. Furthermore, I authorize support for the Patient, family members, friends, and others present.

Physician authorization is mandated in all 50 states EXCEPT Kentucky

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

### 6. WITNESS(es) and/or NOTARY PUBLIC

I/We, the undersigned Witness(es), affirm that all parties signing this document were of sound mind and not subject to coercion, deception, or undue influence. Moreover, I certify that I have witnessed their signatures and have no financial interest stemming from the authorization of this form, including, but not limited to, any involvement in the Patient's estate or that of a relative associated with the Patient's estate.

#### Witnessed by:

[Witness 1 Name]

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

[Witness 2 Name]

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### NOTARY ACKNOWLEDGMENT

**A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.**

State of: \_\_\_\_\_ }

County of: \_\_\_\_\_ }

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me appeared \_\_\_\_\_, as Principal of this **DO NOT RESUSCITATE ORDER** who proved to

me through government issued photo identification to be the above-named person, in my presence executed foregoing instrument and acknowledged that (s)he executed the same as his/her free act and deed.

**Notary Public:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**My commission expires:** \_\_\_\_\_

**Additional signature requirements apply in the following states (alphabetically):**

**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**

**Texas: two (2) additional witnesses or a second (2nd) physician**