DO NOT RESUSCITATE ORDER FOR

_____

ATTENTION! DO NOT MAKE ANY ATTEMPT TO RESUSCITATE THIS PATIENT!

This document represents the official request, legal in the State of _____, to order all medical personnel to cease any attempt to resuscitate the patient and allow a natural death. Section 1, 2, 3, or 4 must be completed along with Section 5.

1. **PATIENT REQUEST**. I, the undersigned patient, direct that resuscitative measures be withheld from me in the event of cardiopulmonary arrest. I have discussed this decision with my physician, and I understand the consequences of this decision.

   Patient's Signature: _____ Date: _____

   Print Name: _____

2. **ADVANCE DIRECTIVE/LIVING WILL**. I, an authorized representative of _____ (Hospital/Medical Facility), hereby attest the patient is no longer competent or able to understand, appreciate, and direct their medical treatment with no hope of regaining that ability. Therefore, I agree to follow a duly executed Advance Directive or Living Will, previously authorized by the patient and made part of their medical record, which includes health care instructions specifying that no life-sustaining treatment is to be provided.

   Representative's Signature: _____ Date: _____

   Print Name: _____

3. **MEDICAL POWER OF ATTORNEY**. I, the agent/attorney-in-fact for the patient, as designated by a duly executed Medical Power of Attorney or equivalent document, reserve the right to make decisions regarding the provision, withholding, or withdrawal of life-sustaining treatment on the patient's behalf. Therefore, I hereby direct that resuscitative measures be withheld from the patient 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 attached and made part of the patient's medical record.

   Agent's Signature: _____ Date: _____

   Print Name: _____

4. **SURROGATE CONSENT**. I, the surrogate certified to make decisions, in consultation with the attending physician, regarding the provision, withholding, or withdrawal of life-sustaining treatment for the patient, hereby direct that resuscitative measures be withheld in the event of the patient's cardiopulmonary arrest. I believe that this decision conforms as closely as possible to what the patient would have wanted. I make this decision in good faith and without consideration of the financial benefit or burden which may accrue to me or to the health care provider as a result of this decision. A copy of the Health Care Surrogate Designation has been attached and made part of the patient's medical record.

   Surrogate's Signature: _____ Date: _____

   Print Name: _____

5. **PHYSICIAN AUTHORIZATION**. Based on the aforementioned information, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold resuscitative measures, i.e., cardiopulmonary resuscitation, chest compression, endotracheal intubation and other advanced airway management, artificial ventilation, cardiac resuscitative mediations, and cardiac defibrillation, in the event of cardiopulmonary arrest in the patient.

   I further direct the implementation of all reasonable comfort care such as oxygen, suction, bleeding control, administration of pain medication by authorized personnel, and other therapies to provide comfort and alleviate the patient's suffering; and to provide support to the patient, family members, friends, and others present.

   Physician's Signature: _____ Date: _____

   Print Name: _____