DO-NOT-RESUSCITATE (DNR) DIRECTIVE

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you **and** your physician (**or** nurse practitioner **or** physician assistant) must complete and sign this form.

FOR PATIENT TO COMPLETE after consultation with his or her health care provider:

In the event that my heart or breathing stops and I am unable to speak for myself, I, _____ (printed name)direct that no efforts be taken to restart my heart or breathing and that Emergency Medical Services (ambulance crews) if notified, honor my directive. I have come to this decision after considering my condition and prognosis and the potential risks, burdens and benefits of refusing efforts to restart my heart or breathing.

I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my physician (**or** nurse practitioner **or** physician assistant) and other caregivers if I change my mind.

I understand that this form is not valid until my physician (**or** nurse practitioner **or** physician assistant) **and** I have signed it.

I understand that in a hospital, nursing home, hospice or home health setting, federal law requires that my physician must include a specific DNR order in my medical record or plan of care, even if we have both signed this form.

☐ No expiration date **OR** ☐ Expires on _____

_____ _____

Patient Signature Date Signed

FOR PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER TO COMPLETE:

By my signature I affirm that:

(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made a voluntary informed decision about resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.

_____ _____

Signature and license level (MD, DO, PA or NP) Date Signed

_____ _____

Printed Name Telephone Number

THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES

Revised February 2008