VERIFICATION OF DO NOT RESUSCITATE ORDER

Dear MD/DO/APRN/PA:

Please complete this card and with the permission of the patient, FAX the entire card to the WV e-Directive Registry, then detach at the perforation, give the bottom of the card to the patient, and keep the top in your records.

REGISTRY FAX: 844-616-1415

Last Name/First/Middle Initial: (Print legibly)

_____

Mailing Address:

_____

City/State/Zip:

_____

Date of Birth (mm/dd/yyyy)

_____/_____/_____

Last 4 SSN

☐☐☐☐

Sex

☐ M ☐ F

Date:_____

DO NOT RESUSCITATE ORDER

As treating Provider of _____
(patient name)

and a licensed MD/DO/APRN/PA, I order that this person **SHALL NOT BE RESUSCITATED** in the event of cardiac or respiratory arrest. This order has been discussed with _____
or his/her representative _____
or his/her surrogate decision maker _____
who has given consent as evidenced by his/her signature below.

MD/DO/APRN/PA Full Name (Printed)_____

MD/DO/APRN/PA Signature _____

Address _____

Person/Surrogate Signature _____

Address _____

Date of Birth (mm/dd/yyyy)