Do Not Resuscitate (DNR) Form

PHYSICIAN

I, is the doctor of the patient confirming that the request of this patient will be followed which means the patient will not be resuscitated in the event of cardiopulmonary arrest or any similar attack. The following procedures are not allowed: intubation, cardiac compression, defibrillation, and similar procedures. However, providing treatment or procedures that may alleviate pain and provide comfort is allowed.

Physician Name

Date Signed

Phone Number

Physician Signature

Email

PATIENT

I, , age years old, residing at ,is under the legal age and willfully signing this form to express and provide instruction to the medical staff to NOT perform resuscitation if I undergo heart arrest, cardiopulmonary arrest, or respirator arrest. To my family, friends, doctor, and health care works, please grant and honor my request.

Name

Date Signed

Phone Number

Patient Signature

Email

WITNESS/LEGAL REPRESENTATIVE

I, declare that I know the person signing this form and this form was signed under my presence and free from any influence.

Legal Guardian/Witness Name

Date Signed

Witness/Legal Representative Signature

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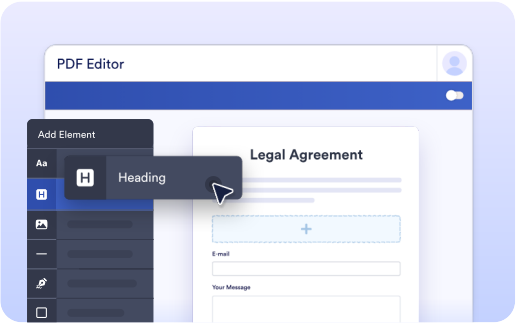

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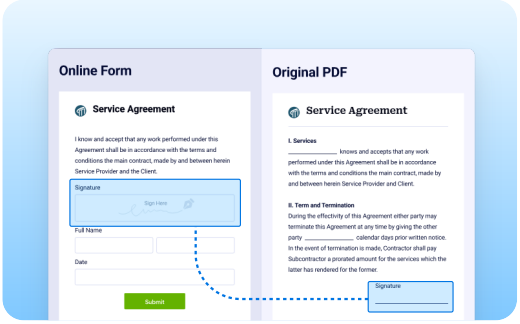

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