The Rest Of Your Life

Outside the Hospital Do-Not-Resuscitate Order

Patient's Full Name______________________________________

I affirm that I have authorized an Outside the Hospital Do- Not - Resuscitate Order for this patient and have documented the grounds for the order in this patient's medical file.

Attending Physician Signature____________________________

Attending Physician (print)________________________________

Address__________________________**Phone**_______________

Date_______________________

I, ____,
(name)
authorize emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from me in the event I suffer cardiac or respiratory arrest.

I understand this means that if my heart stops beating or I stop breathing, no medical procedure to restart heart function or breathing will be instituted.

I understand that I may revoke this order at anytime.
Patient or Patient's Representative
Signature____
Date__________________________