Center for Hospice Care

THIS IS AN ORIGINAL
PLEASE SIGN & RETURN IN 3 DAYS

Do Not Resuscitate Order

Patient: ____ Pt. ID #________________

Physician:____

I have thoroughly discussed my disease process with my physician and am aware that I have a terminal illness, so it is my wish that in the event that my heart would cease to function, I would not want to be resuscitated.

____ ______________________
Patient / Patient Representative Signature Date

____ ______________________
Physician Signature Date

White Copy – Chart *Yellow Copy – Patient* *Pink Copy – Chart*

Revised 01/03
Clinical/DNR Order