

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*

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