



Healing Hands at Home™

Orthopaedic Home Health & Rehabilitation, Inc.

### DO NOT RESUSCITATE REQUEST/ORDER

I, \_\_\_\_\_, hereby affirm my understanding of the following as herein described as permitted by state law and regulation.

*Print Patient Name*

- ▣ I understand "DO NOT RESUSCITATE" means that if my heart stops beating or if I stop breathing, no medical treatment will be started or continued.
- ▣ I understand this decision will not prevent me from obtaining emergency medical care by paramedics and other medical care prior to my death at the direction of my physician.
- ▣ I understand I may revoke this directive at any time.
- ▣ As permitted by state law and regulation, I give permission for this information to be given to paramedics, doctors, nurses, or other health personnel as necessary to implement these directives.

#### Patient must initial statement:

I  DO  DO NOT want a "DO NOT RESUSCITATE" order. *Initial* \_\_\_\_\_

Patient or Legally Authorized Representative Signature: \_\_\_\_\_

Date \_\_\_\_\_

*If signed by patient representative, complete the following:*

Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Cell/Other \_\_\_\_\_

Patient Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Care Manager Signature/Title \_\_\_\_\_ Date \_\_\_\_\_

#### DNR PHYSICIAN ORDERS

This directive is the expressed wish of the above patient.

**DO NOT RESUSCITATE.** In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated.

Physician's Signature \_\_\_\_\_

Phone (s) \_\_\_\_\_ Date \_\_\_\_\_