VERIFICATION OF
DO NOT RESUSCITATE (DNR) ORDER

I understand that DNR means that if my heart stops beating or is inadequate or that if I stop breathing or my breathing is inadequate, that no resuscitation will be initiated or continued.

I understand that I will continue to receive supportive medical care as deemed reasonable by health care personnel though aggressive intervention will not take place.

I give permission for this information to be given to pre-hospital care providers, physicians, nurses or other health personnel as necessary to implement these orders.

I consent to have a DNR identification bracelet placed on my wrist or ankle to indicate my wishes to health care personnel. I am aware that I can immediately revoke this request at any time by the removal of the bracelet and that this order will only be honored if the bracelet is intact and recognized by health care personnel.

____________________________________   ________ – ____ – ______

Patient Signature or Signature of Conservator of Person or Agent for the Health Care
(ATTACH APPOINTMENT FORM)

Patient's social security number

____
Date of Signature

I HAVE WITNESSED THE ABOVE SIGNATURE:

______________	______________________________
Date of Signature	Witness Signature

I CERTIFY THAT THIS PATIENT HAS A WRITTEN DNR ORDER PRESENT IN HIS OR HER MEDICAL RECORD.

______________	___________________________	________________________
Date of Signature	Attending Physician's Signature	Physician's Printed Name

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I have verified the identity of and placed a DNR bracelet on: ________________________

______________	___________________________	________________________
Date of Signature	Signature of Person Applying Bracelet	Printed Name

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Original form to be kept with patient's chart at attending physician's office.
Copies of form to be given to: 1. Patient 2. Designated Agency (if doing patient care planning and applying DNR Bracelet)

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