SYMPONIA HOSPICE
We Are Compassion

Do-Not-Resuscitate Order

Patient Name:_____

I, (Patient/Patient's Representative) _____
request limited health care as described in this document.

Choose the following:

☐ **If** (the patient listed above) heart stops beating or if (the patient listed above) stops breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel. This document does not refer to or include measures that will provide nutritional support or relief of pain.

I understand that I may revoke this consent at any time in one of the following ways: If under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

If not under the care of a health care agency, by destroying my do not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying the attending physician of the revocation.

OR

☐ **Patient chooses full code status. If** (the patient listed above) heart stops beating or if (the patient listed above) stops breathing, patient chooses to receive medical procedures to restore breathing or heart function by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers.
I hereby state that I am making an informed decision and agree to a do-not resuscitate order.

_____ _____
Patient/Patient Representative Signature Date

_____ _____
Signature of Witness Date
(This DNR Consent Form was signed in my, the witness's presence)

_____ _____
Physician's Signature Date

MRN:_____

Created:
Updated: