DO NOT RESUSCITATE (DNR) REQUEST AND DECLARATION

IMPORTANT: THIS DOCUMENT IS NOT A DO-NOT-RESUSCITATE ORDER. It is a written request not to receive CPR. In most states, emergency crews follow only the state's official out-of-hospital DNR form or a POLST-type form (POLST, MOLST, MOST or POST) signed by the patient's physician or other authorized clinician, or approved DNR identification. Take this request to the physician and complete the official form together.

Check one: [ ] I am the patient, signing for myself. [ ] I am the patient's health care agent. [ ] I am the patient's court-appointed guardian. [ ] I am a family member or other surrogate allowed by state law to decide for the patient.

Patient (the "Patient"): _____, born _____, of _____, phone _____.

Representative (if not the Patient): _____, of _____, phone _____, relationship to the Patient _____.
Authority: _____ (for example, a health care power of attorney dated _____, or a court order).

1. WHAT THE PATIENT REQUESTS

If the Patient's heart stops beating or the Patient stops breathing, the Patient does not want cardiopulmonary resuscitation (CPR): no chest compressions, no electric shocks to the heart, no artificial breathing by mouth, mask or bag, no breathing tube placed to revive the Patient, and no drugs given to restart the heart.

[ ] The Patient also does not want a breathing tube or breathing machine started if the Patient has trouble breathing while the heart is still beating (do not intubate).

Other treatment (check one): [ ] all other appropriate treatment, including a trip to the hospital [ ] comfort-focused care; move to a hospital only if comfort needs cannot be met.

This request applies (check any): [ ] at home [ ] in a nursing home or other care facility [ ] during ambulance transport [ ] in a hospital, where the attending physician is asked to enter a matching order.

2. COMFORT CARE

The Patient wants comfort care at all times. Nothing in this request refuses pain relief, oxygen for comfort, suctioning, help for choking, control of bleeding, or other care meant to ease suffering. Hospice provider, if any: _____.

3. REPRESENTATIVE STATEMENT (IF A REPRESENTATIVE SIGNS)

Check one: [ ] The Patient told me, or stated in writing, that the Patient does not want CPR, and I make this request to carry out those wishes. [ ] I do not know the Patient's specific wishes; after talking with the Patient's care team, I believe this request is in the Patient's best interest.

This general template is provided for informational purposes only and does not constitute legal advice. Requirements vary by state and locality; review current law and attach any disclosures or addenda your situation requires before signing. For a guided state-specific document, visit lawvault.org.

I sign in good faith and believe I have the authority described above. I will give the physician proof of that authority on request.

4. REASONS, WISHES AND CONTACTS

Reasons and other wishes (optional): _____

Physician: _____, phone _____. Emergency contact: _____, phone _____. Advance directive signed by the Patient, if any: _____.

5. REVOCATION AND GENERAL TERMS

The Patient may revoke this request at any time by telling the physician or anyone caring for the Patient, by destroying this document, or by signing a written revocation. Any DNR order issued on the state's official form must be revoked too, and any DNR identification removed.

This document is not a medical order. A do-not-resuscitate order exists only when a physician or other authorized clinician issues one on the state's official form or in the Patient's medical record. This request asks only that CPR (and intubation, if checked) be withheld and does not ask anyone to take any action meant to end the Patient's life. If any part cannot be followed, the rest still applies.

I have read this document and understand that without CPR the Patient will probably die if the Patient's heart or breathing stops. Sign in ink; do not sign electronically.

SIGNATURES

Patient or Representative

Signature: _____ Date: _____

Printed Name: _____

WITNESSES (CHECK YOUR STATE’S RULE)

Some states require two adult witnesses for a DNR, and some limit who may serve. Each witness states: I am at least 18. I saw the signer sign this document, or the signer acknowledged the signature to me. The signer appeared to be of sound mind and free of pressure. I am not the Patient's physician or treating clinician, or an employee of one, and I am not the representative who signed.

Witness 1: _____ Printed name: _____ Date: _____

Witness 2: _____ Printed name: _____ Date: _____

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PHYSICIAN SECTION

To be completed only by the Patient's physician or other clinician authorized by state law to issue do-not-resuscitate orders. Completing this section does not replace the state's official form.

Diagnosis and condition: _____

I discussed this request with the Patient or the Patient's representative on _____. Check all that apply: [ ] I issued a DNR order on the state's official form (name: _____) on _____. [ ] I entered a DNR order in the medical record. [ ] I do not agree to issue a DNR order at this time.

Signature: _____ Printed name and title: _____ License number: _____ Date: _____

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