DNR Form

PHYSICIAN INFORMATION

Attending physician's name: _____ Physician's contact information: _____

STATEMENT OF DNR REQUEST

Fill up the following:

DURATION OF DNR ORDER

Select one:

◯ Permanent ◯ Conditional

If conditional, specify conditions/timeframe:

HEALTHCARE PROXY OR LEGAL REPRESENTATIVE (IF APPLICABLE)

Name: _____ Contact information: _____

WITNESS SIGNATURES

I certify that I witnessed the signing of this DNR order by the patient or their legal representative and that I am not related to the patient, involved in their healthcare, or a beneficiary of their estate.

Witness 1: _____

Signature:
Date: _____ dd / mm / yyyy Witness 2: _____

Signature:
Date: _____ dd / mm / yyyy

NOTARY PUBLIC (OPTIONAL)

I hereby certify that the above signatures were executed in my presence, and the patient appeared to be of sound mind and capable of making this decision.

Notary name: _____

Notary signature:
Date: _____ dd / mm / yyyy

COPIES AND DISTRIBUTION

A copy of this form has been provided to the following:

- [ ] Patient
- [ ] Primary care physician
- [ ] Healthcare proxy/legal representative
- [ ] Relevant healthcare providers
- [ ] Emergency medical services (EMS)

The original form is stored in the patient's medical records.

REVIEW AND RENEWAL

This DNR order is subject to periodic review and may be renewed based on changes in the patient's health condition and preferences.

SIGNATURES

Patient (or Legal representative):
Date: _____ dd / mm / yyyy

Attending physician:
Date: _____ dd / mm / yyyy