DNR Form

Physician information	
Attending physician’s name:	
Physician’s contact information:	
Statement of DNR request	
I, _____[patient's name]_____ the undersigned, request that in the event of cardiac or respiratory arrest, no attempt be made to resuscitate me through any means, including but not limited to cardiopulmonary resuscitation (CPR), chest compressions, mouth-to-mouth breathing, advanced airway management, or artificial nutrition. This directive is intended to prevent life-sustaining medical interventions in the event of my breathing stops or I experience cardiac arrest.	
Duration of DNR order	
◯ Permanent ◯ Conditional (Specify conditions/timeframe):	
Healthcare proxy or legal representative (if applicable)	
Name:	
Contact information:	
Witness signature	
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:	**Witness 2**
Signature:	**Signature:**
Date:	**Date:**
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:**

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:

Attending physician:

Date: