Outside the Hospital Do- Not- Resuscitate Identification Card

Patient's Full Name_____

I affirm that I have authorized an Outside the Hospital Do- Not - Resuscitate Order for this patient and have documented the grounds for the order in this patient's medical file.

Attending Physician Signature_____

Attending Physician (print)_____

Address_____Phone_____

Date_____

I, _____,
(name)

authorize emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from me in the event I suffer cardiac or respiratory arrest.

I understand this means that if my heart stops beating or I stop breathing, no medical procedure to restart heart function or breathing will be instituted.

I understand that I may revoke this order at anytime.

Patient or Patient's Representative Signature_____

Date_____