DO NOT RESUSCITATE/DO NOT INTUBATE

I, ____, hereby affirm my understanding of the following limited emergency care as herein described.

(Patient / client must initial each statement.)

- I understand "DO NOT RESUSCITATE" means that if my heart stops beating or if I stop breathing, no medical treatment will be started or continued. Initial: ________
- I understand "DO NOT INTUBATE" means that if I stop breathing, I will not be placed on an artificial breathing machine. Initial: ________
- I understand either or both of these decisions will not prevent me from obtaining emergency medical care by paramedics and other medical care prior to my death at the direction of my physician. Initial: ________
- I understand I may revoke these directives at any time. Initial: ________
- I give permission for this information to be given to paramedics, doctors, nurses, or other health personnel as necessary to implement these directives. Initial: ________

☐ I DO ☐ I DO NOT request and agree to a "DO NOT RESUSCITATE" order Initial: ________

☐ I DO ☐ I DO NOT request and agree to a "DO NOT INTUBATE" order Initial: ________

____ ____________

Print and Sign- Patient/Legal Representative (Attach Power of Attorney if Legal Representative) Date

*Reason patient unable to sign ☐ Unresponsive ☐ Altered Mental Status ☐ Other (specify):

If signed by patient / representative, complete the following:

____ __________________ (_____)___________

Print Name Relationship Phone

____

Patient/Client Street Address, City, State, Zip

****

DNR / DNI PHYSICIAN ORDERS

These directives are the expressed wishes of the patient/ client and discussion regarding these directives has been documented in the clinical record.

- ☐ DO NOT RESUSCITATE. In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated.
- ☐ DO NOT INTUBATE. In the event of acute or impending respiratory failure, endotracheal intubation to provide sustained assisted ventilation shall not be performed. (Do Not Intubate does not prohibit emergency management to prevent or reverse acute airway obstruction with oral, nasal or esophageal obturator airways or treatment of transient respiratory insufficiency with oxygen or short trials of assisted ventilation with positive pressure ventilation equipment or Ambu-bags.)

____ _____________ Date ____/_____/____

Physician's Signature Phone

PATIENT NAME:	PATIENT ID#: