OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDER

Patient's Name: _____ **DOB:** _____

Physician's Statement:
I, the undersigned, state that I am the attending physician of, or have carefully examined, the patient named above. The above-named patient or the patient's surrogate or other person by virtue of that person's legal relationship to the patient, has requested this order, and I have made a determination that this patient is eligible for an order and satisfies one of the following:

(1) The patient has an "end stage medical condition" – an incurable and irreversible medical condition in an advanced state caused by injury disease or physical illness that will, in the opinion of the attending physician to a reasonable degree of medical certainty, result in death, despite the introduction or continuation of medical treatment. …" (Title 20 PA Consolidated Statute 5422) and resuscitative attempts for this patient are not in his / her best interest; or

(2) The patient is permanently unconscious and has a declaration directing that no cardiopulmonary resuscitation be provided to the patient in the event of the patient's cardiac or respiratory arrest; or

(3) The patient is permanently unconscious and has a declaration authorizing the surrogate named below to request an out-of-hospital do-not-resuscitate order for the patient; or

(4) The patient chooses to not want to be resuscitated in the event of a cardiac arrest.

I further certify:

The patient is **CAPABLE** of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of treatment. (Signature of patient is required.)

Patient's Signature:
I, the undersigned, hereby direct that in the event of my cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation (meaning CPR, defibrillation, and intubation with or without assisted ventilation) not be initiated. I understand that I may revoke these directions at any time by physical cancellation or destruction of this form or by orally expressing a desire to be resuscitated.

_____ _____
Patient Date

The patient is **INCAPABLE** of making an informed decision about providing, withholding or withdrawing a specific medical treatment because he / she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

Signature of Designated Agent or Other Authorized Decision Maker:
I, the undersigned, hereby certify that I am authorized to provide consent on the patient's behalf by virtue of my relationship to the patient as _____.
In that capacity, I hereby direct that in the event of the patient's cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation (meaning CPR, defibrillation, and intubation with or without assisted ventilation) not be initiated. I understand that I or the patient may revoke these directions at any time by physical cancellation or destruction of this form or by orally expressing a desire for this patient to be resuscitated.

_____ _____
Authorized Decision Maker Date

_____ _____ _____
Attending Physician (print name) Attending Physician (signature) Date

_____ _____ _____
Physician (print name) Physician (signature) Date

_____ _____ _____
**Physician (print name) Physician (signature) Date

****3rd physician needed only if WSH patient**