



**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**



TRANSFER OF "DO NOT RESUSCITATE" ORDER



Name: _____ Identification Number: _____
Please print

Healthcare Institution: _____

I, the undersigned, attest that the above named person has a valid "Do Not Resuscitate" order
which was written on: _____

By _____, M.D. and is retained in this
person's medical record at the above location.

Signature of M.D. or R.N.

Printed Name

Date