FLORENCE NIGHTINGALE HEALTH CENTER

ADULT RESIDENT'S WRITTEN CONSENT FOR
ISSUANCE OF A DO NOT RESUSCITATE ORDER

Resident's Name ______________________ Date ______________________

Resident's Room# ____________ Resident's ID# ______________________

I, ______________________________ request that ____________________ M.D
(Adult Resident s Name) (Attending Physician s Name)
my Attending Physician, write a Do Not Resuscitate order for me in my Clinical Record. My Attending Physician has fully informed me of my diagnosis, prognosis, the foreseeable risks and benefits of Cardiopulmonary Resuscitation, and the consequences of a Do Not Resuscitate order. I understand and appreciate the nature and consequences of a Do Not Resuscitate order, including its benefits and disadvantages and am making this request based on my informed decision.
My specific limitations or instructions concerning this request are.

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__________________________________ __________________________________

(Signature of Resident) Date

WITNESSES CERTIFICATIONS.
The above-named resident of this Facility has expressed in writing, and in my presence, his/her consent to the issuance of a Do Not Resuscitate Order.

______________________________ ______________________________

(Signature of Witness #1) (Signature of Witness #2)

______________________________ ______________________________

(Print Name of Witness #1) (Print Name of Witness #2)

______________________________ ______________________________

(Title/Relationship to Resident) (Title/Relationship to Resident)