

Authorization and Order For Withholding Cardiopulmonary Resuscitation

Re:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Resident Name

Cardiopulmonary Resuscitation (“CPR”) refers to a range of procedures used to attempt to restore heartbeat and breathing following a cardiopulmonary arrest. Basic CPR refers to a means of opening and maintaining an airway, providing ventilation through rescue breathing and providing artificial circulation through the use of external cardiac compression. The time which elapses between a heart stoppage and the initiation of resuscitation greatly influences the chance of survival and recovery.

A Do Not Resuscitate (DNR) Order is an order issued by the resident’s treating physician which directs that, in the event of cardiac or respiratory arrest, no CPR measures will be initiated. Other emergency procedures will be initiated for crisis situation where there is no cardiac or respiratory arrest (i.e. choking, bleeding, shock, etc.). This facility does not have the equipment or personnel to perform life support procedures more advanced than basis CPR or to monitor residents for cessation of cardiopulmonary function.

In the event of a cardiopulmonary arrest, emergency medical personnel will be summoned by calling 911 and CPR will be initiated unless there is either evidence of irreversible death, or the resident has a valid DNR Order issued by the resident’s treating physician, and located in the resident’s clinical record

I hereby state that I desire that a **Do Not Resuscitate Order** be issued by the treating physician and that I am aware and agree to a **Do Not Resuscitate Order**. I also understand that this **Do Not Resuscitate** request does not take effect until the treating physician has issued a written **Do Not Resuscitate Order** that has been received by the facility and placed in the resident’s clinical chart.

Signature of Resident

Signature of Responsible Party (Circle Relationship: Guardian, Attorney in Fact [Power of Attorney for Health Care Decisions], Family Member)

Witness Date

**I HEREBY ISSUE A DO NOT RESUSCITATE ORDER**

Signature of Physician Date and Time