Center for Hospice Care

THIS IS AN ORIGINAL
PLEASE SIGN & RETURN IN 3 DAYS

Do Not Resuscitate Order

Patient: _____ DOB:_____

Physician:_____

I have thoroughly discussed my disease process with my physician and am aware that I have a terminal illness, so it is my wish that in the event that my heart would cease to function, I would not want to be resuscitated.

_____ _____
Patient / Patient Representative Signature Date

_____ _____
Physician Signature Date

Revised 02/18
Clinical/DNR Order

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