DO NOT RESUSCITATE (DNR) DIRECTIVE

(An Advance Request to Limit the Scope of Emergency Medical Care)

I, _____, request limited emergency care as herein described:

- I understand DNR means that if my heart stops beating, or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.
- I understand this decision will not prevent me from obtaining other emergency medical care by pre-hospital care providers or medical care directed by a physician prior to my death.
- I understand I may revoke this directive at any time.
- I give permission for this information to be given to the pre-hospital care providers, physicians, nurses, or other health care personnel as necessary to implement this directive.

I hereby agree to the "DNR" directive.

_____ _____

Signature Date

WITNESS:

_____ _____

Signature Date

**Witness must by 18 years of age or older, not related to the Declarant by blood or marriage, not entitled to any portion of the Declarant's estate according to the Kansas Laws of intestate succession or under any will of the Declarant or codicil thereto, and not directly financially responsible for the Declarant's medical care expenses.

ATTENDING PHYSICIAN:

**I affirm this directive is the expressed wish of the patient, is medically appropriate, and is documented in the patient's permanent medical record.

In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated.

_____ _____

Attending Physician's Signature Date

_____ _____

Facility/Agency Name Address

**Signature of physician is not required if the above-named person is a member of a church or religion which, in lieu of medical care and treatment, provides treatment by spiritual means through prayer alone and care consistent therewith in accordance with the tenets and practices of such church or religion.

REVOCATION PROVISION

I hereby revoke the above Declaration.

_____ _____

Signature Date
