State of Florida

DO NOT RESUSCITATE ORDER

(please use ink)

Patient’s Full Legal Name: ________________________________________________ Date:____________________

(Print or Type Name)

PATIENT’S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.

(If not signed by patient, check applicable box):

☐ Surrogate  ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian  ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

________________________________________________________________________________________________

(Applicable Signature) (Print or Type Name)

PHYSICIAN’S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient’s cardiac or respiratory arrest.

________________________________________________________________________________________________

(Signature of Physician) (Date) Telephone Number (Emergency)

________________________________________________________________________________________________

(Print or Type Name) (Physician’s Medical License Number)

DH Form 1896, Revised December 2002