DNR
DO-NOT-RESUSCITATE DIRECTIVE

K.S.A. 65-4941, ET. SEQ.

DECISION TO LIMIT EMERGENCY MEDICAL CARE

I, (Your name)_____, request that effective today, emergency care for me will be limited as described below.

If my heart stops beating or if I stop breathing, no medical procedures to restart breathing or heart functioning will be instituted. No resuscitation will be attempted.

- I understand that the procedure I am refusing, known as cardiopulmonary resuscitation, (CPR), includes chest compressions, assisted ventilations, intubation, defibrillation, administration of cardiotonic medications and other related medical procedures.
- I do not intend for this decision to prevent me from obtaining other medical care, especially comfort measures and pain medication.
- I understand I may revoke this directive at any time.
- I give permission for this information to be given to emergency care providers, doctors, nurses or other health care personnel.
- This DNR directive shall remain in effect while I am admitted at a medical care facility or care home as well as during transport to or from a home or facility.

X_____ _____
(Signature) (Date)

X _____ _____
(Witness signature) (Date)

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Attending Physician Order: I have discussed the use of cardiopulmonary resuscitation with this patient and recognize the patient's decision to refuse CPR.

- In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation shall be attempted. **DNR**

X _____ _____
(Attending Physician's Signature) (Date)

_____ _____
(Address) (Facility, Clinic or Hospital Name)

Revocation: I hereby withdraw the above DNR directive.

X_____ _____
(Signature) (Date)

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Additional forms and information are available-Telephone (316) 684-1991, **www.kansashealthethics.org.**

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