PRE-HOSPITAL DNR REQUEST FORM

AN ADVANCED REQUEST TO LIMIT THE SCOPE OF EMERGENCY MEDICAL CARE

K.S.A. 65-4942

I,_____, _____, _____, request limited emergency care as herein described.
name | date of birth (optional) | last four digits of SSN (optional)

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 my permission for this information to be given to the pre-hospital care providers, doctors, nurses, or other health care personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) directive.

_____ _____
Signature | Date

_____ _____
Witness | Date

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

_____ _____
Address | Facility or Agency Name

* Signature of physician not required if the above-named 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