

DNR IDENTIFICATION FORM

A printed copy of this order form or other authorized DNR identification must accompany the patient during transports and transfers between facilities.

Patient Name:	Patient Birth Date: / /
Optional Patient or Authorized Representatives Signature	

Printed name of Physician, APRN, or PA*	Date
REQUIRED Signature of Physician, APRN, or PA	Phone
REQUIRED For APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician's NPI, DEA, or Ohio medical license number.	

CHECK ONLY ONE BOX BELOW

☐**DNR Comfort Care - Arrest** Providers will treat patient as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will be implemented.

☐**DNR Comfort Care** The following DNR protocol is effective immediately.

DNR PROTOCOL

Providers Will:	**Providers Will Not:**
• Conduct an initial assessment • Perform Basic Medical Care • Clear airway of obstruction or suction • If necessary, may administer oxygen, CPAP or BiPAP • If necessary, may obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death • If possible, may contact other appropriate health care providers (hospice, home health, physician, APRN, or PA)	• Perform CPR • Administer resuscitation medications with the intent of restarting the heart or breathing • Insert an airway adjunct • Defibrillate, cardiovert, or initiate pacing • Initiate continuous cardiac monitoring

Physicians, emergency medical services personnel, and persons acting under the direction of or with the authorization of a physician, APRN or PA who participate in the withholding or withdrawal of CPR from the person possessing the DNR identification are provided **immunities under section 2133.22 of the Revised Code**. This DNR order is effective until revoked and may not be altered. Any medical orders, instructions, or information, other than those required elements of the form itself, that are written on this order form are not transportable and are not provided protections or immunities.

* A DNR order may be issued by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) when authorized by section 2133.211 of the Ohio Revised Code.

Kentucky Emergency Medical Services
Do Not Resuscitate (DNR) Order

Person's Full Legal Name: _____

Surrogate's Full Legal Name (if applicable): _____

I, the undersigned person or surrogate who has been designated to make health care decisions in accordance with Kentucky Revised Statutes, hereby direct that in the event of my cardiac or respiratory arrest that this ***DO NOT RESUSCITATE (DNR) ORDER*** be honored. I understand that DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart function, more specifically the insertion of a tube into the lungs, or electrical shocking of the heart or cardiopulmonary resuscitation (CPR) will be started by emergency medical services (EMS) personnel.

I understand this decision will *not* prevent emergency medical services personnel from providing other medical care.

I understand that I may revoke this DNR order at any time by destroying this form, removing the DNR bracelet, or by telling the EMS personnel that I want to be resuscitated. Any attempt to alter or change the content, names, or signatures on the EMS DNR form shall make the DNR form invalid.

I understand that this form, or a standard EMS DNR bracelet must be available and must be shown to EMS personnel as soon as they arrive. If the form or bracelet is not provided, the EMS personnel will follow their normal protocols which could include cardiopulmonary resuscitation (CPR) or other resuscitation procedures. I understand that should I die, EMS personnel will require this form and/or bracelet for their records.

I give permission for information about this EMS DNR Order to be given to the prehospital emergency medical care personnel, physicians, nurses, or other health care personnel as necessary to implement this directive.

I hereby state that this ***'Do Not Resuscitate (DNR) Order'*** is my authentic wish to ***not*** be resuscitated.

_____ _____

Person/Legal Surrogate Signature **Date**

Commonwealth of Kentucky County of _____

Subscribed and sworn to before me by _____to be his/her own free act and deed, this _____day of _____, 20_____.

_____, Notary Public

My commission expires: _____

In lieu of having this Form notarized, it may be witnessed by two persons not related to the individual noted above.

WITNESSED BY:

1. _____

2. _____

Verification of the original document

☐ **Upon transfer out of the facility:**
This document is a copy generated on the current date from an original document maintained in the patient's chart, is true to the original, and recognized to be in full force.

_____

Signature of person sending patient *Date*

☐ **Upon transfer back to the facility:**
This signed copy was received during the admission of the patient and to the treatment team's reasonable knowledge, the DNR remains in effect at the date of the discharge.

_____

Signature of person returning patient *Date*

This EMS Do Not Resuscitate Form was approved by the Kentucky Board of Medical Licensure at their March 2024 meeting.

Complete the portion below, cut out, fold, and insert in DNR bracelet.

I certify that an EMS Do Not Resuscitate (DNR) form has been executed.

Person's Name (print/type)_____Person's / Legal Surrogate's Signature_____

Reset Form

STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

State Form 49559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:
My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant

Printed name of declarant

City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness	Printed name	Date *(month, day, year)*

Signature of witness	Printed name	Date *(month, day, year)*

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician

Printed name of attending physician	Medical license number	Date *(month, day, year)*