

**STATE OF ARKANSAS
EMERGENCY MEDICAL SERVICES
DO NOT RESUSCITATE ORDER**

Patient's Full Name: _____

Signature of Patient or Health Care Proxy or Legal Guardian

Date

ATTENDING PHYSICIAN'S ORDER

I, the undersigned, state that I am the physician for the patient named above.

I hereby direct any and all qualified Emergency Medical Services personnel, commencing on the effective date noted below, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide to the patient other medical interventions such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

Signature of Attending Physician

Physician's Telephone number (emergency #)

Physician's Printed/Typed Name

Date Order Written

