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# EMERGENCY MEDICAL SERVICES
# PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

California Medical Association

I, _____, request limited emergency care as herein described.
*(print patient's name)*

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 prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

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

_____ _____

Patient/Legally Recognized Health Care Decisionmaker Signature | Date

_____

Legally Recognized Health Care Decisionmaker's Relationship to Patient

*By signing this form, the legally recognized health care decisionmaker acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.*

I affirm that this patient/legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____

Physician Signature | Date

_____ _____

Print Name | Telephone

*THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY*

## PREHOSPITAL DNR REQUEST FORM

| | |
|---|---|
| White Copy: | To be kept by patient |
| Yellow Copy: | To be kept in patient's permanent medical record |
| Pink Copy: | If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381 |