State of Florida
DO NOT RESUSCITATE ORDER

(please use ink)

Patient's Full Legal Name:____Date: _________________________

(Print or Type Name)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

☐ Surrogate ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

____
(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

( ) -
____
(Signature of Physician) (Date) Telephone Number (Emergency)

____
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2004

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PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F .S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

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(Signature of Physician) (Date) Telephone Number (Emergency)

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(Print or Type Name) (Physician's Medical License Number)

DH Form 1896,Revised December 2004

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Patient's Full Legal Name (Print or Type) (Date)

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(Applicable Signature) (Print or Type Name)