EMERGENCY MEDICAL SERVICES
OVERSIGHT AUTHORITY

555 South 70th Street
Lincoln, NE 68510

1600 South 48th Street
Lincoln, NE 68506

PHYSICIAN'S DO NOT RESUSCITATE (DNR) ORDER FOR THE MEDICALLY ILL

I, _____ , have been diagnosed as having a medical illness. I have discussed both the prognosis of this illness and the treatment options with my physician and request that in the event of my cardiopulmonary arrest, cardiopulmonary resuscitation and/or mechanical ventilations not be initiated.

I give permission for this information to be given to Emergency Medical Service and Mobile Health Care personnel, physicians, nurses, or other health care personnel as necessary to carry out these wishes. I understand that this order is valid from this point forward until rescinded by either myself or my designated Durable Power of Attorney for Health Care, and further agree that a copy of this form is as valid as the original. Incomplete forms may be returned as being invalid.

☐ **DO NOT INTUBATE** I understand that **DO NOT INTUBATE** means that in the event that my breathing is inadequate I do not wish a tube placed in my airway to maintain my respirations artificially.

☐ **DO NOT RESUSCITATE (DNR**) I understand that DNR means that if my heart stops beating, or is inadequate, or that if I stop breathing or my breathing is inadequate, that no artificial resuscitation will be initiated or continued. I understand that I will continue to receive supportive medical care as deemed appropriate by health care personnel, though cardiopulmonary resuscitation will not take place.

_____ _____

Patient, or Next of Kin Signature or Guardian of Person or Durable Power of Attorney for Health Care (Attach Appointment form).

Date

_____ _____

Patient Address (Including facility name if applicable)

Witness

I certify that I have discussed his or her medical illness, treatment and prognosis with the patient and that the entry of this DNR order is appropriate for:

_____ _____

Patient Name

Date of Birth

_____ _____ Date:__/__/__

Printed Physician Name

Physician Signature

_____ Date: __/__/__

Agency Completing Form and Signature of Agency Representative (required if "By Telephone Order box below is checked)

☐ By telephone order, the patient's attending physician referenced above was consulted regarding the DNR status, however, was unavailable to personally appear to provide an original signature. The agency representative above verifies the consultation and authorization of the physician as indicated.

Copy Distribution:

☐ *Patient File

☐ Home Health/Hospice Agency

☐ Attending Physician

☐ Patient's Home (if applicable)

*Original DNR form must be kept in patient's primary medical file.

***KEEP IN PROMINENT PLACE**

DNR ORDER