



## Durable Do Not Resuscitate Order

VIRGINIA DEPARTMENT OF HEALTH

Patient's Full Legal Name \_\_\_\_\_ Date \_\_\_\_\_

### Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify [must check 1 or 2]:

- 1. The patient is CAPABLE of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required; see reverse.)
- 2. The patient is INCAPABLE of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B or C below:

- A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.
- B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf" is required; see reverse.)
- C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf" is required; see reverse.)

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

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Emergency Phone Number

**Important – Emergency Medical Services Providers cannot honor copies of the Durable Do Not Resuscitate Order. They must have the original yellow form.**

## Patient's Signature

I, the undersigned, hereby direct that in case of my cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation not be initiated and not be continued once initiated. I understand that I may revoke these directions at any time by physical cancellation or destruction of this form or by orally expressing a desire to be resuscitated to qualified health care personnel. I also understand that if qualified health care personnel have any doubts about the applicability or validity of this order, they will begin cardiopulmonary resuscitation.

\_\_\_\_\_  
Signature of Patient

## Signature of Person Authorized to Consent on the Patient's Behalf

I, the undersigned, hereby certify that I am authorized to provide consent on the patient's behalf by virtue of my relationship to the patient as \_\_\_\_\_ (in order of priority: designated agent, guardian or committee, spouse, adult child, parent, adult brother or sister, other relative in descending order of blood relationship). In that capacity, I hereby direct that in case of the patient's cardiac or respiratory arrest, efforts at cardiopulmonary resuscitation not be initiated and not be continued once initiated. I understand that I may revoke these directions at any time by physical cancellation or destruction of this form or by orally expressing a desire to be resuscitated to qualified health care personnel. I also understand that if qualified health care personnel have any doubts about the applicability or validity of this order, they will begin cardiopulmonary resuscitation of the patient.

\_\_\_\_\_  
Signature of Person Authorized to Consent on the Patient's Behalf

## EMS Personnel Will Look for This Order in the Following Places:

- ① On the back of the door leading to the patient's bedroom
- ② On the bedside table, beside the patient's bed
- ③ On the refrigerator
- ④ In the patient's wallet
- ⑤ On an approved alternate form of identification (bracelet or necklace)