

Effective Date: _____ to _____

(Not to exceed 6 months)



**Non-Hospital
DO NOT RESUSCITATE ORDER**
For Implementation by Division of DD Facility

Individual's full name: _____ DOB _____

In the event of cardiac and/or pulmonary arrest of the individual as a result of the following terminal condition _____, the following efforts at cardiopulmonary resuscitation of the individual SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the Missouri Revised Statute 459.010-459.055.

Signature of Attending Physician

Printed Name of Attending Physician

Address

City, State, Zip