

**Alabama Portable Physician Do Not Attempt Resuscitation Order  
No CPR/ Allow Natural Death**

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**Patient/Resident Full Name (PRINT) and Date of Birth:**

**Instructions. This order is valid only if Section I, II, III, OR IV is completed AND a physician has completed Section V.**

**Section I. Patient/Resident Consent.**

I, the undersigned patient/resident, direct that resuscitative measures be withheld from me in the event of cardiopulmonary cessation. I have discussed this decision with my physician, and I understand the consequences of this decision.

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**Signature of Patient/Resident**

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**Date**

**Section II. Incompetent Patient/Resident with DNAR instructions in Advance Directive.**

The patient/resident is not competent or is no longer able to understand, appreciate, and direct his/her medical treatment and has no hope of regaining that ability. A duly executed Advance Directive for Health Care with instructions that no life sustaining treatment be provided was previously authorized by the patient/resident and is part of his/her medical record.

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**Signature of provider or facility representative**

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**Print Name**

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**Date**

**Section III. Health Care Proxy or Attorney-in-Fact Consent.**

I, the undersigned, am the health care proxy or attorney-in-fact designated by the patient/resident to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/resident. I hereby direct that resuscitative measures be withheld from the patient/resident in the event of cardiopulmonary cessation. A copy of the proxy or attorney-in-fact designation (e.g., living will, power of attorney, etc.) has been made part of the patient/resident's medical record.

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**Signature of Proxy or Attorney-in-Fact**

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**Print Name**

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**Date**

**Section IV. Surrogate Consent.**

I, the undersigned, am the surrogate certified to make decisions, in consultation with the attending physician, regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/resident. After consultation with the attending physician, I hereby direct that resuscitative measures be withheld from the patient/resident in the event of cardiopulmonary cessation. I believe that this decision conforms as closely as possible to what the patient/resident would have wanted. I make this decision in good faith and without consideration of the financial benefit or burden which may accrue to me or to the health care provider as a result of this decision. A copy of the Certification of Health Care Decision Surrogate has been made part of the patient/resident's medical record.

\_\_\_\_\_  
Signature of Surrogate

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Section V. Physician Authorization.**

Based on the information above, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold resuscitative measures, i.e., cardiopulmonary resuscitation, chest compression, endotracheal intubation and other advanced airway management, artificial ventilation, cardiac resuscitative medications, and cardiac defibrillation, in the event of cardiopulmonary cessation in the patient/resident.

I further direct the implementation of all reasonable comfort care such as oxygen, suction, control of bleeding, administration of pain medication by personnel so authorized, and other therapies to provide comfort and alleviate suffering by the patient/resident; and to provide support to the patient, family members, friends, and others present.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date