**Patient's or Authorized Agent's Directive to Withhold Cardiopulmonary Resuscitation (CPR)**
This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

## Patient's Information

Patient's Name_____
(Printed Name)

*If Applicable-* Name of Agent/Legally Authorized Guardian/Parent of Minor Child _____
(Printed Name)

Date of Birth: _____/____/_____ Gender: ☐ Male ☐ Female Eye Color: _____ Hair Color: _____

Race Ethnicity : ☐ Asian or Pacific Islander ☐ Black, non-Hispanic ☐ White, non-Hispanic
☐ American Indian or Alaska Native ☐ Hispanic ☐ Other

*If Applicable*- Name of hospice program/provider: _____

## Physician's Information

Physician's Name: _____
(Printed Name)

Physician's Address: _____

Physician's telephone: ( ) _____ Physician's Colorado License #: _____

## Directive Attestation

Check **ONLY** the information that applies:

☐ Patient: I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.

☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child: I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient's heart or breathing stops or malfunctions, the patient will not receive CPR and may die.

☐ Tissue Donation: I hereby make an anatomical gift, to be effective upon my death of:
☐ Any needed tissues
The following tissues: ☐ Skin ☐ Cornea ☐ Bone, related tissues and tendons

**I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient's care and comfort. If I/the patient am/is admitted to a health care facility, this directive shall be implemented as a physician's order, pending further physician's orders.**

_____ _____
☐ Signature of Patient
☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child
Physician Signature

_____ _____
Date Date