CCFORM 9/2006



MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH OFFICE OF EMERGENCY MEDICAL SERVICES

COMFORT CARE / DO NOT RESUSCITATE ("DNR") ORDER VERIFICATION

PATIENT'S LAST NAME			
PATIENT'S FIRST NAME	PATIENT'S MIDDLE	NAME OR INITIAL	
DATE OF BIRTH (MM/DD/YYYY) GENDER M F			
STREET OR RESIDENTIAL ADDRESS			
CITY	STA	TE ZIP CODE (5 or 9 digit	ts)
LAST NAME OF GUARDIAN OR HEALTH CARE AGENT (If applicable)			
FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT	MIDDLE NAME OR	INITIAL	
PATIENT/GUARDIAN/HHEALTH CARE AGENT STATEMENT (SIGNATURE AND I verify that the above named patient has a current and valid Do Not Resuscitate orde form, the DNR order, if current and valid, will be recognized in out-of-hospital setting Order Verification Protocol will be followed by emergency medical services personned.	(□patient □ guardian □ "DNR order"). I understand the	nat by signing this	
Signature of Patient/Guardian/Health Care Agent		Date	
Signature of Patient/Guardian/Health Care Agent PHYSICIAN / NURSE PRACTICIONER (NP) / PHYSICIAN ASSISTANT (PA) VERIFALWAYS REQUIRED) I am an attending physician / NP / PA for the above named patient. I verify that the a order, issued on This DNR order	ove named patient has a currers is an expiration date, it is in the husetts Department of Public	PA SIGNATURE AND DATES ent and valid Do Not Resuscit indicated below, and this : Health, Office of Emergency	ate
PHYSICIAN / NURSE PRACTICIONER (NP) / PHYSICIAN ASSISTANT (PA) VERIFICAL ALWAYS REQUIRED) I am an attending physician / NP / PA for the above named patient. I verify that the a order, issued on This DNR order	ere is an expiration date, it is in the setts Department of Public and to the above named patients	PA SIGNATURE AND DATES ent and valid Do Not Resuscit indicated below, and this : Health, Office of Emergency	Medical Order

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