



# DO NOT RESUSCITATE

## ALL FIRST RESPONDERS AND EMERGENCY MEDICAL SERVICES PERSONNEL ARE AUTHORIZED TO COMPLY WITH THIS OUT-OF-HOSPITAL DNR ORDER.

This request for no resuscitative attempts in the event of a cardiac and/or respiratory arrest for: \_\_\_\_\_, has been ordered by the physician whose signature appears below. PLEASE PRINT NAME This order is in compliance with the patient's/surrogate's wishes and it has been determined and documented by the physician below that resuscitation attempts for this patient would be medically inappropriate.

It is expected that this DNR order shall be honored by all *Emergency Medical Services (EMS)* personnel, *First Responders*, and other healthcare providers who may have contact with this patient during a medical emergency.

PATIENT/SURROGATE SIGNATURE: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

### THE ABOVE NAMED PATIENT IS UNDER THE CARE OF:

PHYSICIAN NAME: \_\_\_\_\_ PLEASE PRINT NAME

PHYSICIAN ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER:(        ) \_\_\_\_\_ - \_\_\_\_\_

MEDICAL FACILITY AFFILIATION: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**THIS DOCUMENT SHOULD BE PROMINENTLY DISPLAYED  
AND READILY AVAILABLE TO EMS PERSONNEL  
(see reverse for instructions)**

### INSTRUCTIONS FOR FIRST RESPONDERS/EMS

**ALL PATIENTS HAVE THE RIGHT TO MAKE HEALTHCARE DECISIONS INCLUDING THE RIGHT TO ACCEPT OR REFUSE LIFE-SAVING MEDICAL TREATMENT.**

- 1. ASSESS THE PATIENT FOR THE ABSENCE OF BREATHING AND/OR HEARTBEAT.**
- 2. IF THE PATIENT IS NOT IN CARDIAC AND/OR RESPIRATORY ARREST, PROVIDE ALL NECESSARY CARE, INCLUDING TRANSPORT IF REQUIRED.**
- 3. IF THE PATIENT IS IN CARDIAC AND/OR RESPIRATORY ARREST, DO NOT INITIATE CPR AND RESUSCITATIVE EFFORTS.**
- 4. FOLLOW LOCAL EMS PROTOCOLS FOR PRONOUNCEMENT.**
- 5. DOCUMENT ALL PERTINENT INFORMATION ON YOUR RUN SHEET AND ATTACH A COPY OF THIS OUT-OF-HOSPITAL DNR ORDER.**
- 6. ONLY THE INDIVIDUAL(S) (PATIENT, SURROGATE, OR PHYSICIAN) WHO SIGNED THIS FORM MAY RESCIND IT AT ANY TIME.**
- 7. PHOTOCOPIES OF THIS DOCUMENT ARE PERMITTED AND SHALL BE HONORED AT ALL TIMES.**

**THIS DOCUMENT, ITS INTENT AND ASSOCIATED POLICIES ARE SUPPORTED BY:**

**Medical Society of New Jersey  
New Jersey Department of Health and Senior Services  
New Jersey Chapter, American College of Emergency Physicians  
New Jersey State Nurses Association  
New Jersey HealthDecisions  
New Jersey Association of Osteopathic Physicians and Surgeons  
Academy of Medicine of New Jersey  
New Jersey MICU Program Administrators Association  
MICU Advisory Council  
New Jersey State First Aid Council**

**IF THERE ARE ANY QUESTIONS CONCERNING THE TREATMENT AND/OR PRONOUNCEMENT OF THIS PATIENT, CALL:**

**CONTACT PERSON:\_\_\_\_\_ TELEPHONE:(     ) \_\_\_\_\_ - \_\_\_\_\_**

**AGENCY:\_\_\_\_\_**