

OKLAHOMA DO-NOT-RESUS	SCITATE (DNR) CONSENT FORM
described in this document. If my hear medical procedure to restore breathing	rt stops beating or if I stop breathing, no g or heart function will be instituted by any t limited to, emergency medical services
	t prevent me from receiving other health or oxygen and other comfort care measures.
I understand that I may revoke thi following ways:	is consent at any time in one of the
	are agency, by making an oral, written, or ysician or other health care provider of a
	th care agency, by destroying my do-not- ot-resuscitate identification from my person, an of the revocation;
•	ot-resuscitate consent by written notification provider of the health care agency or by oral
- · · · · · · · · · · · · · · · · · · ·	ot-resuscitate consent by destroying the all do-not-resuscitate identification from my
I give permission for this information nurses, and other health care providers informed decision and agree to a do-n	ot-resuscitate order.
Signature of Person	Signature of Representative (Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Advance Directive Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)
Date	This DNR consent form was signed in my presence.
Duie	
Signature of Witness	Address

Address

 $Signature\ of\ Witness$

CERTIFICATION OF PHYSICIAN

This form is to be used by an attending physician only to certify that an incapacitated person without a representative would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. An attending physician of an incapacitated person without a representative must know by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that such person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Clear and convincing evidence for this purpose shall include oral, written, or other acts of communication between the patient, when competent, and family members, health care providers, or others close to the patient with knowledge of the patient's desires.

I hereby certify, based on clear and believe that	nd convincing evidence presented to me, that I
	Name of Incapacitated Person
in the event of cardiac or respirat respiratory arrest, no chest compr	administration of cardiopulmonary resuscitation ory arrest. Therefore, in the event of cardiac or ressions, artificial ventilation, intubations, iac medications are to be initiated.
Physician's Signature	Physician's Name (PRINT)
Physician's Address/Phone	
Date	

This DNR consent form and Certification of Physician is copied from Senate Bill 1325. This law is effective November 1, 2010.

This form is available online at:

http://www.okdhs.org/divisionsoffices/visd/asd/ under Quick Links