OUTSIDE THE HOSPITAL DO-NOT-RESUSCITATE (OHDNR) ORDER

I, _____, authorize emergency medical services personnel to
(name)
withhold or withdraw cardiopulmonary resuscitation from me in the event I suffer cardiac or respiratory arrest. Cardiac arrest means my heart stops beating and respiratory arrest means I stop breathing.

I understand that in the event that I suffer cardiac or respiratory arrest, this OHDNR order will take effect and no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care and medical interventions, such as intravenous fluids, oxygen or therapies other than cardiopulmonary resuscitation such as those deemed necessary to provide comfort care or to alleviate pain by any health care provider (e.g. paramedics) and/or medical care directed by a physician prior to my death.

I understand I may revoke this order at any time.

I give permission for this OHDNR order to be given to outside the hospital care providers (e.g. paramedics), doctors, nurses, or other health care personnel as necessary to implement this order.

I hereby agree to the "Outside The Hospital Do-Not-Resuscitate" (OHDNR) Order.

Patient – Printed or Typed Name	Date
Patient's Signature or Patient Representative's Signature	Date

REVOCATION PROVISION I hereby revoke the above declaration.	
Patient's Signature or Patient Representative's Signature	Date

I AUTHORIZE EMERGENCY MEDICAL SERVICES PERSONNEL TO WITHHOLD OR WITHDRAW CARDIOPULMONARY RESUSCITATION FROM THE PATIENT IN THE EVENT OF CARDIAC OR RESPIRATORY ARREST.
I affirm this order is the expressed wish of the patient/patient's representative, medically appropriate and documented in the patient's permanent medical record.

Attending Physician's Signature **(Mandatory)**		Date
Attending Physician – Printed or Typed Name	Attending Physician's License No.	Attending Physician's Telephone No.
Address – Printed or Typed		Facility or Agency Name

THIS OHDNR ORDER SHALL REMAIN WITH THE PATIENT WHEN TRANSFERRED OUTSIDE THE HEALTH CARE FACILITY.
Emergency Medical Services personnel shall not comply with an outside the hospital do-not-resuscitate order when the patient or the patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated or if the patient is or is believed to be pregnant. Emergency medical services personnel shall not comply with a OHDNR order or the OHDNR protocol when the patient under eighteen (18) years of age, either parent of such patient, the patient's legal guardian, or the juvenile or family court if the patient is under juvenile court jurisdiction under section 211.031, RSMo expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire for the patient to be resuscitated.

Statutory citation 190.600-190.621 RSMo

Outside the Hospital Do-Not Resuscitate Order Definitions and Protocol

DEFINITIONS OF KEY TERMS FOR THE OUTSIDE THE HOSPITAL DO-NOT RESUSCITATE (DNR) ORDER

Attending physician	(1) A physician licensed under Chapter 334, RSMo, selected by or assigned to a patient who has primary responsibility for treatment and care of the patient; or (2) If more than one physician shares responsibility for the treatment and care of a patient, one such physician who has been designated the attending physician by the patient or the patient's representative shall serve as the attending physician.
Cardiopulmonary resuscitation (CPR)	Emergency medical treatment administered to a patient in the event of the patient's cardiac or respiratory arrest, and shall include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures.
Emergency medical services personnel	Paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, advanced emergency medical technicians, paramedics, or other emergency service personnel acting within the ordinary course and scope of their professions but excluding physicians.
Outside the hospital do-not resuscitate identification	A standardized identification card, bracelet, or necklace of a single color, form and design as set forth in 19 CSR 30-40.600 that signifies that the patient's attending physician has issued an outside the hospital do-not resuscitate order for the patient and has documented the grounds for the order in the patient's medical file.
Outside the hospital do-not resuscitate order	A written physician's order signed by the patient and the attending physician, or the patient's representative and the attending physician, which authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of cardiac or respiratory arrest.
Patient	A person eighteen years of age or older who is not incapacitated, as defined in section 475.010, RSMo, and who is otherwise competent to give informed consent to an outside the hospital do-not-resuscitate order at the time such order is issued, and who, with his or her attending physician, has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621, RSMo. A person who has a patient's representative shall also be a patient for the purposes of sections 190.600 to 190.621, RSMo, if the person or the person's patient's representative has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621, RSMo. A person under eighteen (18) years of age shall also be a patient for purposes of sections 190.600 to 190.621, RSMo if the person has had a do-not-resuscitate order issued on his or her behalf under the provisions of section 191.250, RSMo
Patient's representative	(1) An attorney in fact designated in a durable power of attorney for health care for a patient determined to be incapacitated under sections 404.800 to 404.872, RSMo; or (2) A guardian or limited guardian appointed under Chapter 475, RSMo, to have responsibility for an incapacitated patient. A patient under the age of eighteen (18) years may have an OHDNR order signed by at least one (1) parent; by at least one (1) of the patient's legal guardian(s); or by a juvenile or family court under the provisions of section 191.250, RSMo, if the patient is under juvenile court jurisdiction under section 211.031, RSMo.

OUTSIDE THE HOSPITAL DO-NOT- RESUSCITATE (OHDNR) PROTOCOL

Emergency medical services personnel are authorized to comply with the OHDNR protocol when presented with OHDNR identification or an OHDNR order. The Outside the Hospital Do Not Resuscitate (OHDNR) protocol includes the following standardized methods or procedures:

(1) An OHDNR order shall only be effective when the patient has not been admitted to or is not being treated within a hospital or has not yet come to the emergency department as defined in the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395dd, and the regulation 42 C.F.R. 489.24(a) and referenced in the Centers for Medicare and Medicaid Services State Operations Manual Appendix V – Interpretive Guideline – Responsibilities of Medicare Participating hospitals in Emergency Cases (Rev. 191, 07-19-19);

(2) Emergency medical services personnel shall not comply with an OHDNR order or the OHDNR protocol when the patient or patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated;

(3) Emergency medical services personnel shall not comply with a OHDNR order or the OHDNR protocol when the patient under eighteen (18) years of age, either parent of such patient, the patient's legal guardian, or the juvenile or family court if the patient is under juvenile court jurisdiction under section 211.031, RSMo expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire for the patient to be resuscitated;

(4) An OHDNR order shall not be effective during such time as the patient is pregnant;

(5) A properly executed OHDNR order authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of cardiac or respiratory arrest. Emergency medical services personnel shall not withhold or withdraw other medical interventions, such as intravenous fluids, oxygen, or therapies other than cardiopulmonary resuscitation such as those to provide comfort care or alleviate pain. Nothing in this regulation shall prejudice any other lawful directives concerning such medical interventions and therapies;

(6) If any doubt exists about the validity of the OHDNR identification or an OHDNR order, resuscitation shall be initiated and medical control shall be contacted;

(7) If the OHDNR order or OHDNR identification is presented after Basic or Advanced Life Support procedures have started, the emergency medical services personnel shall honor the form and withhold or withdraw cardiopulmonary resuscitation from a patient who is suffering cardiac or respiratory arrest;

(8) After noting the properly executed OHDNR order or OHDNR identification, no cardiac monitoring is necessary and no medical control contact is necessary; and

(9) Emergency medical services personnel shall document review of the OHDNR order and/or OHDNR identification in the patient care record.

Outside the Hospital Do- Not- Resuscitate Identification Card

Patient's Full Name_____

I affirm that I have authorized an Outside the Hospital Do- Not - Resuscitate Order for this patient and have documented the grounds for the order in this patient's medical file.

Attending Physician Signature_____

Attending Physician (print)_____

Address_____**Phone**_____

Date_____

I, _____,
(name)

authorize emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from me in the event I suffer cardiac or respiratory arrest.

I understand this means that if my heart stops beating or I stop breathing, no medical procedure to restart heart function or breathing will be instituted.

I understand that I may revoke this order at anytime.

Patient or Patient's Representative

Signature_____

Date_____

Medical Record #:

Alaska POLST (Physician Orders for Life Sustaining Treatment) Form

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an Advance Directive.

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/_____/_____ State where form was completed:_____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location, unless another treatment preference is documented in Section C of this form.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Discussed but no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (optional)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (optional)

If other than patient, print full name of person consenting (or non-opposition in instance of guardian)		**Authority:**

F. SIGNATURE: Health Care Provider (required, eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have confirmed that this order was discussed with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in Alaska may sign this order.]

✖ (required)	**Date** (mm/dd/yyyy): Required / /	**Phone # :**
Printed Full Name:		**License/Cert. #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. Version 1, June 3, 2020.

Alaska POLST Form – Page 2 *******ATTACH TO PAGE 1********

Patient Full Name:

Form Completion Information (required)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed:_____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Physician's Assistant ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Contact Information (optional)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )

Primary Care Provider Name: Phone: ( )

☐ Patient is enrolled in hospice Name of Agency: Agency Phone: ( )

Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by Alaska Statute, and in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in Alaska (M.D./D.O.) can sign this form.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
  - The most recently completed valid POLST form supersedes all previously completed POLST forms.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable).
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- This form may be added to a secure electronic registry so health care providers can find it.

For Barcodes / ID Sticker

Copied, faxed or electronic versions of this form are legal and valid. Version 1, 10.2019

STATE OF ARKANSAS
EMERGENCY MEDICAL SERVICES
DO NOT RESUSCITATE ORDER

Patient's Full Name: _____

_____ _____
Signature of Patient or Health Care Proxy or Legal Guardian Date

ATTENDING PHYSICIAN'S ORDER

I, the undersigned, state that I am the physician for the patient named above.

I hereby direct any and all qualified Emergency Medical Services personnel, commencing on the effective date noted below, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide to the patient other medical interventions such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

_____ _____
Signature of Attending Physician Physician's Telephone number (emergency #)

_____ _____
Physician's Printed/Typed Name Date Order Written

Georgia Department of Public Health

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

This is a Physician Order guided by the patient's medical condition and based upon personal preferences verbalized to the Physician or expressed in an Advance Directive.

Patient's Name _____ _____ _____
(First) (Middle) (Last)

Last four digits of SSN:_____ Date of Birth _____ Gender: Male ☐ Female ☐

A CODE STATUS Check all that apply	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** ☐ Resuscitation Orders are to remain in effect during any surgical or invasive procedure. When not in cardiopulmonary arrest, follow orders in **B, C** and **D.**
B Check One	**MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.** ☐ **Comfort Measures**: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.* ☐ **Limited Additional Interventions**: Includes **Comfort Measures** and medical treatment, IV fluids, and cardiac monitor as indicated. Does not include intubation or mechanical ventilation. *Avoid intensive care. Transfer to hospital if indicated.* ☐ **Additional Treatment**: Includes **Limited Additional Interventions**, lab tests, blood products. *Transfer to hospital if indicated.* ☐ **Full Treatment**: Includes **Additional Treatment** and intubation, mechanical ventilation, and cardioversion as indicated. *Includes intensive care. Transfer to hospital if indicated.* ☐ Additional Orders (e.g. dialysis):
C Check One	**ANTIBIOTICS** ☐ No antibiotics: Use other measures to relieve symptoms. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. ☐ Additional Orders:
D Check One In Each Column	**ARTIFICIALLY ADMIINISTERED NUTRITION/FLUIDS** **Where indicated, always offer food or fluids by mouth if feasible** ☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. ☐ Additional Orders: ☐ No IV fluids. ☐ Defined trial period of IV fluids. ☐ Long-term IV fluids.
E Check All That Apply	**REASON FOR ORDERS AND SIGNATURES** To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences as indicated by: ☐ My discussion with the Patient ☐ My discussion with the Patient's Authorized Representative ☐ My review of the Patient's Advance Directive ☐ Verbal consent was given for an "allow natural death" order

Physician's Printed Name License No. State	Physician's Signature	Date Phone	
Patient's Printed Name	Patient's Signature	Date	Phone
Patient Authorized Representative's Printed Name (if patient lacks decision making capacity)	Representative's Signature (if patient lacks decision making capacity)	Date	Phone

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

- This form should be completed by a health care professional based on the patient's medical condition, and on the patient's wishes, as expressed to the physician by the patient while in a competent condition, or in the patient's advance directive, or by a representative of the patient acting with legal authority.
- This form should be signed by a physician, **and** also by the patient **or,** if the patient lacks decision making capacity, a representative acting with legal authority on behalf of the patient.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms are valid.
- **Any incomplete section of POLST implies full treatment for that section.**
- Do not use a defibrillator (including AEDs) on a person who has chosen "allow natural death."
- Always offer fluids and nutrition by mouth if medically feasible.
- Transfer the patient to a setting better able to provide comfort when it cannot be achieved in the current care setting (*e.g.*, treatment of a hip fracture).
- A patient with capacity, or the authorized representative of a patient without capacity, may request alternative treatment.
- **Treatment of dehydration is a measure which prolongs life. A patient who desires IV fluids should indicate "Limited Additional Intervention" or higher level of care.**

SUBSEQUENT REVIEW OF THE POLST FORM

This form should be reviewed when (i) the patient is transferred from one care setting or care level to another (ii) released to return home (iii) there is substantial change in the patient's health status, or (iv) the patient's treatment preferences change. **If this POLST is voided, replaced, or becomes invalid, then draw a line through sections A though D, write "VOID" in large letters with date and time, and sign by the line.** After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

Date/Time of Review	Location of Review	Print Name of Reviewer	Outcome of Review	Physician Signature
			☐ No Change ☐ Form Voided, new form completed ☐ Form Voided, no new form	
			☐ No Change ☐ Form Voided New Form Completed ☐ Form Voided, no new form	

This form was prepared by the Georgia Department of Public Health pursuant to Official Code of Georgia Section 29-4-18(l). O.C.G.A. § 29-4-18(k)(3) provides: *"Any person who acts in good faith in accordance with a Physician Order for Life-sustaining treatment developed pursuant to subsection (l) of this Code section shall have all of the immunity granted pursuant to Code Section 31-32-10."* **O.C.G.A. § 31-32-10 provides, in pertinent part:** *"Each health care provider, health care facility, and any other person who acts in good faith reliance … shall be protected and released to the same extent as though such person had interacted directly with the [patient] as a fully competent person."*

STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

State Form 49559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:
My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant
Printed name of declarant
City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness	Printed name	Date *(month, day, year)*
Signature of witness	Printed name	Date *(month, day, year)*

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician		
Printed name of attending physician	Medical license number	Date *(month, day, year)*

EMS DNR

INSTRUCTIONS

Purpose

This standardized **EMS-DNR Order (Order)** has been developed by the EMS Bureau within the Epidemiology and Response Division of the New Mexico Department of Health (DOH). It is in compliance with Section 24-10B-4I, NMSA 1978 which directs the EMS Bureau to develop a program to authorize EMS providers to honor advance directives to withhold or terminate care. The program is described fully in NMAC 7.27.6. A copy may be obtained by calling the EMS Bureau at 505-476-8200 or online at www.nmems.org.

For covered persons in cardiac or respiratory arrest, resuscitative measures to be withheld include external chest compressions, intubation, defibrillation, administration of cardiac medications and artificial respiration. The **Order** does not effect the provision of other emergency medical care, including oxygen administration, suctioning, control of bleeding, administration of analgesics and comfort care.

Applicability

This **Order** applies only to resuscitation attempts by health care providers in the **prehospital** setting --i.e., in patients' homes, in a long term care facility, during transport to or from a heath care facility, or in other locations outside acute care hospitals.

Instructions

Any adult person may execute an **Order** in conjunction with a physician. The physician, or physician's designee, shall explain to the person the full meaning of the **Order**, the available alternatives and how the **Order** may be revoked. Both the physician, or the physician's designee upon a verbal order from the physician, and the person for whom the **Order** is executed, shall sign the **Order**.

If the person for whom the **Order** is contemplated is unable to give informed consent, or is a minor, the physician, or physician's designee, shall provide the same explanation of the **Order**, the available alternatives, and how the **Order** may be revoked to an authorized heath care decision maker. If the authorized health care decision maker gives informed consent, both the physician, or the physician's designee upon a verbal order from the physician, and the authorized health care decision maker shall sign the document

ONE SIGNED COPY of the **Order** should be retained by the patient and placed in an envelope. Staple the Envelope Cover Sheet (which is included in this PDF document) **"EMS DNR Order inside"** to the envelope. The completed form (and/or the approved EMS bracelet or neck medallion) must be readily available to EMS personnel in order for the **Order** to be honored. Resuscitation attempts may be initiated until the form (or EMS bracelet/medallion) is presented and the identity of the patient is confirmed by the EMS personnel. It is recommended that the white envelope containing the **Order** be located in an obvious place that is readily available to emergency responders.

ONE SIGNED COPY should be retained by the physician and made part of the patient's permanent medical record. Additional copies should be made so that the **Order** can be maintained in all of the appropriate medical records.

ONE SIGNED COPY of the form may be used by the patient to order an ***optional*** EMS bracelet or neck medallion inscribed with the words "DO NOT RESUSCITATE - EMS" The MedicAlert Foundation (2323 Colorado Avenue, Turlock, CA 95382) is the EMS Bureau approved supplier of the medallions, which will be issued only upon receipt of the properly completed **Order** (together with an enrollment form and the appropriate fee). If a MedicAlert enrollment form is needed, call 1.888.633.4298 and ask for an EMS-DNR form. The fee can be waived for patients who cannot afford it, as certified by the physician or the physician's designee. Although optional, use of an EMS-DNR bracelet facilitates prompt identification of the patient and therefore is strongly encouraged.

Revocation

An **Order** may be revoked at any time orally or by performing an act such as burning, tearing, canceling, obliterating or by destroying the order of any part of it by the person on whose behalf it was executed or by the persons' authorized health care decision maker. If an **Order** is revoked, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with MedicAlert Foundation. All medallions and associated wallet cards should be destroyed.

Additional Resources available

To obtain a New Mexico Durable Power of Attorney for Health Care Decision Form or a Values History Form, contact the Center for Health Law and Ethics, 1111 Stanford, N.E., Albuquerque NM 87131 or call 505-277-5006. The cost for the Values form is $3.00 and may be requested in English or Spanish.

EMS-DNR forms may be downloaded from the EMS Bureau's website, www.nmems.org. For DNR program implementation questions, please call the EMS Bureau at 505-476-8200 .

ENVELOPE COVER SHEET

EMS DNR

ORDER INSIDE

EMS DNR

EMERGENCY MEDICAL SERVICES (EMS) DO NOT RESUSCITATE (DNR) FORM

AN ADVANCE DIRECTIVE TO LIMIT THE SCOPE OF EMS CARE

NOTE: THIS ORDER TAKES PRECEDENCE OVER A DURABLE HEALTH CARE POWER OF ATTORNEY FOR EMS TREATMENT ONLY

I, _____, request limited EMS care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart functioning will be instituted, by any health care provider, including but not limited to EMS personnel.

I understand that this decision will not prevent me from receiving other EMS care, such as oxygen and other comfort care measures.

I understand that I may revoke this Order at any time.

I give permission for this information to be given to EMS personnel, doctors, nurses and other health care professionals. I hereby agree to this DNR order.

_____ OR _____

Signature

Signature/Authorized Health Care Decision Maker

I affirm that this patient/authorized health care decision maker is making an informed decision and that this is the expressed directive of the patient. I hereby certify that I or my designee have explained to the patient the full meaning of the Order, available alternatives, and how the Order may be revoked. I or my designee have provided an opportunity for the patient/authorized health care decision maker to ask and have answered any questions regarding the execution of this form. A copy of this Order has been placed in the medical record. In the event of cardiopulmonary arrest, no chest compressions, artificial ventilations, intubation, defibrillation, or cardiac medications are to be initiated.

_____ _____

Physician's Signature/Date

Physician's Name—PRINT

_____

Physician's Address/Phone

Note: please print three (3) copies

ONE SIGNED COPY: To be kept by patient in white envelope and immediately available to Emergency Responders
ONE SIGNED COPY: To be kept in patient's permanent medical record
ONE SIGNED COPY: If DNR Bracelet/Medallion is desired send to MedicAlert with enrollment form