Background
Advance care planning is the process of thinking about values and choices for medical care and discussing them with family and health care providers. New Hampshire House Bill 656, pertaining to advance directives and do not attempt resuscitation orders (DNR), is effective on January 1, 2007. The intent of the legislation is to update the law so that honoring patient choices is as simple as possible. The changes in law, related educational efforts and new forms should always be understood in the context of understanding what health care the patient wants or does not want. Forms are tools for the patient to communicate but should not be a barrier to listening and respecting patient choices. An advance directive is only a written document or tool to help communicate the patient’s decisions. Understanding and honoring a patient’s choices is the important task of health providers in delivering quality care.

Education Modules for Selected Audiences have been developed
1. Physicians/nurse practitioners ARNP
2. Nurses/Social workers/Chaplains
3. Patient/family
4. EMS/ED physicians /ED nurses
5. Health Administrators

All current education materials may be found at the FHC website – www.healthynh.com.

Do Not Attempt Resuscitation Order and Advance Directive Document: What is the difference?
Advance care planning is the process of thinking about values and choices for medical care and discussing them with family and health care providers. The distinction between an advance directive document and do not attempt resuscitation orders is often a confusing one. An advance directive document are important written guides in determining the medical care a patient receives towards the end of his or her life. An advance directive can include a patient’s wishes regarding many different types of medical decisions, treatments, and procedures. A do not attempt resuscitation (DNR) order is the medical order that documents the patient’s decision not to have clinicians attempt resuscitation in the event of a cardiac or respiratory arrest.

In New Hampshire, the term advance directive refers specifically and only to a single legal document with two separate sections: a Durable Power of Attorney for Health Care and a Living Will. A Durable Power of Attorney for Health Care (DPOAH) states that if a patient loses the capacity to make medical decisions for him or herself, that patient grants authority to another adult of his or her choosing to make the decisions. “Losing capacity” means that the patient cannot generally understand the significant risks and
benefits of a health care decision, as well as any alternative options. A physician or advanced registered nurse practitioner (ARNP) must determine and record when a patient loses capacity and the DPOAH is activated or put into effect. In the context of this law, “capacity” is a medical judgment, as opposed to “competency”, which is determined in a court of law. A Living Will states that if a patient is diagnosed with a medical condition which renders him or her near death or permanently unconscious without hope of recovery, and the patient is unable to actively participate in the decision-making process, that patient wishes to have all life-sustaining treatment withheld or withdrawn. A patient must specifically indicate whether this applies to medically administered nutrition or hydration.

While a patient’s advance directive document may make reference to their wishes regarding whether they want to be resuscitated or not, these documents do not constitute a DNR order. A DNR order is an official medical order, written by a physician or ARNP on either a standardized institutional order form or on a state-recognized portable DNR order form. It documents the patient’s choice not to have clinicians attempt resuscitation if they go into cardiac or respiratory arrest. The purpose of the DNR order is to translate the patient’s wishes into an actual medical order that will subsequently direct the care of that patient in the health care facility. In contrast, an advance directive document lets the patient’s wishes regarding treatment be known, but these wishes must also be translated into doctor’s orders in order to take effect in the health care setting.

**RSA 137-J: MASTER BULLET POINTS**

1. **Purpose and Policy**
   a. Every person has a right to control decisions related to their health care.
   b. Every person has a right to create an advance directive.
   c. Every person has a right to have a do not attempt resuscitation (DNR) order written.
   d. Advance directive and DNR orders are voluntary. No person is required to have either one.

2. **Definitions**
   *Advance directive*: a directive allowing a person to give directions about future medical care or to designate another person to make medical decisions if he or she should lose the capacity to make health care decisions. “Advance directives” includes living wills and durable powers of attorney for health care.

   *Living will*: a legal document which states that no life-sustaining treatment will be given to a person once that person has been diagnosed and certified in writing by their attending physician or ARNP to be near death or permanently unconscious, without hope of recovery, and is unable to actively participate in the decision-making process.

   *Durable power of attorney for health care (DPOAH)*: a legal document giving another adult the authority to make health care decisions for a person in the event that the person does not have capacity to make those decisions for him or herself.

   *Do not attempt resuscitation order or DNR order*: an order that, in the event of an actual or imminent cardiac or respiratory arrest, chest compression and ventricular defibrillation will not be performed, the patient will not be intubated or manually ventilated, and there will be no administration of resuscitation drugs. DNR orders only take effect in the event of actual or imminent cardiac or respiratory arrest; they do not affect other routine medical care.
Capacity to make health care decisions: the ability to generally understand and appreciate the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care. In the context of this law, “capacity” is a medical judgment, as opposed to “competency”, which can only be determined in a court of law.

Near death: an incurable condition caused by injury, disease, or illness which is such that death is imminent. The application of life-sustaining treatment would, to a reasonable degree of medical certainty, only postpone the moment of death. This must be determined and documented by 2 separate physicians or a physician and an ARNP.

Permanently unconscious: a lasting condition, indefinitely without improvement, in which thought, awareness of self and environment, and other indicators of consciousness are absent as determined by an appropriate neurological assessment by a physician in consultation with the attending physician or ARNP.

Cardiopulmonary resuscitation: those measures used to restore or support cardiac or respiratory function in the event of a cardiac or respiratory arrest. These generally include chest compressions, assisted ventilation, intubation, intravenously-administered cardiotonic medication, and defibrillation.

Health care decision: informed consent, refusal to give informed consent, or withdrawal of informed consent to any type of health care, treatment, admission to a health care facility, any service or procedure to maintain, diagnose, or treat an individual’s physical or mental condition except as prohibited otherwise by law.

Life-sustaining treatment: any medical procedures or interventions which use mechanical or other medically administered means to sustain, restore, or replace a vital function which, in the written judgment of the attending physician or ARNP, would serve only to artificially postpone the moment of death, and where the person is near death or is permanently unconscious. “Life-sustaining treatment” includes, but is not limited to, the following: mechanical respiration, kidney dialysis or the use of other external mechanical or technological devices. Life sustaining treatment may include drugs to maintain blood pressure, blood transfusions, and antibiotics. “Life-sustaining treatment” shall not include the administration of medication, natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide comfort or to alleviate pain.

Attending physician or attending advanced registered nurse practitioner (ARNP): the physician or advanced registered nurse practitioner, selected by or assigned to a patient, who has primary responsibility for the treatment and care of that patient. If more than one physician or advanced registered nurse practitioner shares that responsibility, any one of those physicians or advanced registered nurse practitioners may act as the attending physician or ARNP.

Do not attempt resuscitation identification: a standardized identification necklace, bracelet, card, or written medical order that signifies that a “Do Not Attempt Resuscitation Order” has been issued for the patient.

Medically administered nutrition and hydration: invasive procedures such as, but not limited to the following: nasogastric tubes; gastrostomy tubes; intravenous feeding or hydration; and hyperalimentation. It shall not include the natural ingestion of food or fluids by eating and drinking.
3. Freedom from Influence
   a. No person can be charged a different rate for their health care based on whether or not they have an advance directive or DNR order.
   b. Medical fees must be the same, regardless of whether a person is making their own health care decisions, or those decisions are being made by their designated health care agent.
   c. No person can be refused services, admission to a facility, or health insurance based on whether or not they have an advance directive or DNR order.
   d. An advance directive cannot affect the sale or issuance of any life insurance policy, nor can it affect the terms of a person’s current life insurance policy.
   e. Any health care provider or residential care provider which does not recognize DNRs or living wills must post a notice at every place of admission (minimum size of 8 1/2” x 11”) stating in legible print: “This hospital/facility does not honor Do Not Attempt Resuscitation (DNR) or Living Will documents.”

4. Agent’s Health Care Responsibilities
   Definition of Agent: in an advance directive, the adult designated by the patient to have authority to make that patient’s health care decisions in the event the patient lacks capacity.
   Definition of Principal: a person 18 years of age or older who has executed an advance directive.
   a. An agent cannot be the principal’s health care provider or residential care provider.
   b. An agent cannot be an employee of the principal’s health care provider or residential care provider, unless they are a relative of the principal.
   c. The agent has the authority to make any and all health care decisions on the principal’s behalf that the principal could make only when the principal does not have capacity to make health care decisions, unless otherwise prohibited by law.
   d. Lack of capacity must be certified in writing by the principal’s attending physician or ARNP and the agent’s name must be noted and placed in the principal’s medical record.
   e. The agent must make health care decisions in accordance their knowledge of the principal’s wishes and religious or moral beliefs. If the principal’s wishes are unknown, the agent must make decisions in accordance with the principal’s best interests and in accordance with accepted medical practice.
   f. If the principal regains capacity to make health care decisions, the authority to make health care decisions reverts to the principal. The regaining of capacity must be certified in writing by the principal’s attending physician or ARNP in the principal’s medical record.
   g. If, because of religious or moral beliefs, the principal has no attending physician or ARNP, the principal may designate a person who can determine that he or she lacks capacity. This person must be identified in the principal’s advance directive. In this case, lack of capacity must be certified in writing and acknowledged before a notary or justice of the peace. The person designated by the principal cannot be the agent or a person ineligible to be the agent.
   h. Even if the principal lacks capacity and an advance directive is in effect, the attending physician or ARNP must make reasonable efforts to inform them of proposed treatment or any proposal to withdraw or withhold treatment. If the principal objects to the proposed plan, even if they lack capacity and an advance directive is in effect, the
principal’s vocalized wishes must be honored. The only exception to this is if the principal’s advance directive includes the following statement initialed by the principal: “Even if I am incapacitated and I object to treatment, treatment may be given to me against my objection.” It is important to note that in this type of situation, a family member or health care provider may petition the Probate Court to appoint a Guardian if they believe the patient is not able to give informed consent. Furthermore, health care providers are never required to do anything that would not be accepted medical practice.

i. An agent may not give consent to any of the following:

- Voluntary admission to any state institution
- Voluntary sterilization
- Withholding life-sustaining treatment from a pregnant principal unless, to a reasonable degree of medical certainty, the treatment or procedures will not allow the continuing development and live birth of the fetus or will be physically harmful to the principal or prolong severe pain which cannot be alleviated by medication. This must be documented on the principal’s medical record by the attending physician or ARNP and an obstetrician who has examined the principal.

j. The agent must make health care decisions in accordance with their knowledge of the principal’s wishes and religious or moral beliefs. If the principal’s wishes are unknown, the agent must make decisions in accordance with the principal’s best interests and in accordance with accepted medical practice.

5. Agent’s Legal Rights

a. If the principal has been determined to lack capacity and therefore the agent’s authority is in effect, and as long as the action is not prohibited by the principal’s advance directive, the agent can:

- Request and receive any information, oral or written, regarding the principal’s physical or mental health, including, but not limited to, medical and hospital records.
- Execute any releases or other documents which may be required in order to obtain such medical information.
- Consent to the disclosure of such medical information.

b. No agent can be held criminally or civilly liable for making a health care decision for the principal, so long as they make that decision in accordance with New Hampshire law.

6. Physician, ARNP, and Provider’s Health Care Responsibilities

What determines how and when a patient’s advance directive has gone into effect?

A patient’s advance directive goes into effect if that patient loses the capacity to make medical decisions for him or herself. “Losing capacity” means that the patient cannot generally understand the risks and benefits of a health care decision, as well as any alternative options.

a. If a patient’s advance directive has gone into effect, that patient’s attending physician or ARNP, or that patient’s health care provider or residential care provider and employees of the facility, must follow the directions given by the patient’s designated agent in their DPOAH or by that patient’s living will directions, as long as they are within the bounds of reasonable medical practice and they do not violate New Hampshire law.
b. If the principal asks, the advance directive or a copy of it must be placed in the medical record.

c. If any person has a copy of a patient’s advance directive and that person becomes aware that the advance directive may come into effect, that person must give the advance directive to the patient’s health care provider or residential care provider.

d. If it is determined that a patient with an advance directive lacks capacity and/or the patient is near death or permanently unconscious, the patient’s attending physician or ARNP must take the necessary steps to document this as quickly as possible so that the patient’s advance directive may be honored.

e. If a physician or ARNP cannot comply with the terms of the advance directive, the direction of the agent, or the direction of the living will because of his or her personal beliefs or conscience, he or she must immediately inform the patient, the patient’s family, or the patient’s agent. The patient, patient’s family, or agent may then request a referral to another physician or ARNP. Furthermore, he or she must immediately make the necessary arrangements to transfer the patient and the medical records that document the patient’s lack of capacity to another physician or ARNP who has been chosen by the patient, the patient’s agent, or the patient’s family. While awaiting the completion of the transfer, the attending physician or ARNP cannot deny health care treatment, nutrition, or hydration which, if denied, would, within a reasonable degree of medical certainty, result in or hasten the patient’s death against the will of the patient, the advance directive, or the agent. The physician or ARNP cannot incur liability for their refusal to carry out the advance directive, as long as all of these steps are adhered to.

7. Physician, ARNP, and Provider’s Legal Rights
a. If the principal has been determined to lack capacity and therefore the agent’s authority is in effect, health care providers, residential care providers, and persons acting for such providers or under their control can communicate to the agent any medical information necessary for the purpose of helping the agent make health care decisions. Health care providers, residential care providers, and persons acting for such providers or under their control may also provide copies of the principal’s advance directives to the agent, if it is necessary to facilitate treatment.

b. No health care provider or residential care provider, or any other person acting for the provider or under the provider’s control, can be held criminally or civilly liable, or be deemed to have engaged in unprofessional conduct, for acting according to an advance directive so long as it is within New Hampshire law, or for any failure to follow the directions of an agent if the health or residential care provider believes that the direction exceeds the scope or authority of the agent.

8. Withholding or Withdrawal of Life-Sustaining Treatment
a. Medically administered nutrition and hydration and life-sustaining treatment can not be withdrawn based on an advance directive UNLESS:
   - The principal clearly expresses that this is his or her wish in their advance directive or
   - Such treatment would have the unintended consequence of hastening death or causing irreparable harm. This must be certified by an attending physician and a physician knowledgeable about the patient’s condition, or
   - Withholding or withdrawing life-sustaining treatment is pursued through court-appointed guardianship or another court order.
b. If one of the above conditions is met, and the agent decides to withhold or withdraw life-sustaining treatment but the principal does not have the “Living Will” part of the advance directive, the following additional conditions apply:

- The principal’s attending physician or ARNP must certify in writing that the principal lacks the capacity to make health care decisions.
- The physician or ARNP, as well as another physician, must certify in writing that the principal is near death or is permanently unconscious.
- The agent must make a good faith effort to explore all avenues reasonably available to determine the desires of the principal. This includes, but is not limited to, the principal’s advance directive, the principal’s written or spoken expressions of wishes, and the principal’s known religious or moral beliefs.

c. Nothing in this law condones, authorizes, or approves suicide, assisted suicide, mercy killing, or euthanasia. The law serves only to permit the natural process of dying in a patient who is near death, or to withdraw life-sustaining treatment from a patient who is permanently unconscious.

d. While withholding or withdrawal of life-sustaining treatment under the guidelines of the law is never considered murder or suicide, it will not relieve any individual of responsibility for any criminal acts that may have caused the principal’s condition.

e. Life-sustaining treatment can not be withheld or withdrawn from a pregnant principal unless, to a reasonable degree of medical certainty, the treatment or procedures will not allow the continuing development and live birth of the fetus, or the treatment or procedures will be physically harmful to the principal or prolong severe pain which cannot be alleviated by medication. This must be documented on the principal’s medical record by the attending physician or ARNP and an obstetrician who has examined the principal.

f. Life-sustaining treatment can not be withheld or withdrawn from a mentally incompetent or developmentally disabled person, unless that person has a validly executed advance directive, or the action is authorized by an existing guardianship or other court order, or the action is taken in accordance with the facility’s standard protocol as applicable to its general patient population.

g. It should never be presumed that in the absence of an advance directive, a person wants life-sustaining treatment to be either withheld or withdrawn.

9. Use of Statutory Forms

a. Every person who wishes to create an advance directive will be provided with a disclosure statement prior to the creation of the advance directive. The principal is required to sign a statement acknowledging that he or she has received the disclosure statement and has read and understands it.


10. Execution and Witnesses.

a. The advance directive must be signed by the principal in the presence of either:

- Two or more witnesses, neither of whom can be the agent, the principal’s spouse or heir at law, or a person entitled to any part of the estate of the principal upon death of the principal under a will, trust, or other testamentary instrument or deed in existence or by operation of law, or attending physician or ARNP, or person
acting under the direction or control of the attending physician or ARNP. No more than one such witness may be the principal’s health or residential care provider or such provider’s employee. The witnesses shall affirm that the principal appeared to be of sound mind and free from duress at the time the advance directive was signed and that the principal affirmed that he or she was aware of the nature of the document and signed it freely and voluntarily, OR

- A notary public or justice of the peace.

b. If the principal is physically unable to sign, the advance directive may be signed by the principal’s name written by some other person in the principal’s presence and at the principal’s direction.

c. A principal’s decision to exclude or strike references to ARNPs and the powers granted to ARNPs in his or her advance directive shall be honored.

11. Revocation of an Advance Directive

a. An advance directive can be revoked by:

- Written revocation, signed and dated by the principal, and given to the agent, health care provider, or residential care provider, OR
- Oral revocation by the principal in the presence of two or more witnesses, none of whom can be the principal’s spouse or heir at law, OR
- Any other act by the principal showing intent to revoke the directive, such as burning or tearing it, OR
- Any act by another person, directed by the principal and in their presence, showing intent to revoke the directive, OR
- Creating a new advance directive, OR
- Court determination that an agent’s authority has been revoked, OR
- Filing for a divorce, legal separation, annulment, or protective order between the principal and the agent. If there is an alternate agent listed on the advance directive, the advance directive is not revoked, but instead authority is granted to the alternately designated agent. If the principal wants to keep the original primary agent as their primary agent, there must be a written re-affirmation or a new advance directive must be created.

b. If a principal’s health or residential care provider is informed of a revocation of an advance directive, they must immediately record the revocation, with the time and date when the revocation was received, in the principal’s medical record and notify the agent, the attending physician or ARNP, and staff responsible for the principal’s care.

c. If an agent becomes aware of a revocation, they must inform the principal’s health or residential care provider. The revocation shall become effective upon communication to the attending physician or ARNP.

12. Documents from Other States

An advance directive created in another state must be honored, so long as it was created in accordance with that state’s law. However, the advance directive is subject to requirements of New Hampshire state law regarding an advance directive.

13. Documents Created Prior to Enactment of HB 656 on 1/1/07

An advance directive created under prior New Hampshire law must still be honored under the new law.
14. Naming of Multiple Agents
If more than one person is listed as the agent in a Durable Power of Attorney for Health Care document, the agents have authority in the order they are listed on the document. If another method of joint agency is desired by the principal (for example, all agents must agree on any action taken), that method must be specified in writing in the directive.

15. Conflict Between Living Will and DPOAH
If there is a conflict between a terminal care document or living will and a durable power of attorney for health care, the durable power of attorney for health care governs.

16. Civil Action
   a. The principal, or any person who is a near relative of the principal, or who is a responsible adult who is directly interested in the principal by personal knowledge and acquaintance (this includes guardians, social workers, physicians, or clergy members), may feel that the principal was not of sound mind or was under duress, fraud, or undue influence when the advance directive was executed. In this case, that person can file an action in the probate court of the county where the principal is located requesting that the authority granted to an agent by an advance directive be revoked.
   b. This person may also file an action challenging the authority of any agent and naming another person to be appointed guardian over the person of the principal for the sole purpose of making health care decisions, so long as this other person agrees to act as the guardian.
   c. A copy of any of the above actions must be given to the principal’s attending physician or ARNP and to the principal’s health care provider or residential care provider (if applicable). At that point, health care decisions made by a challenged agent must not be implemented without an order of the probate court or a withdrawal or dismissal of the court action.
   d. The probate court in which the petition is filed must hold a hearing as quickly as possible.

17. Penalty
A person who knowingly and falsely makes, alters, forges, or counterfeits, or knowingly and falsely causes to be made, altered, forged, or counterfeited, or procures, aids or counsels the making, altering, forging, or counterfeiting, of an advance directive or revocation of same with the intent to injure or defraud a person shall be guilty of a class B felony.

18. Presumed Consent to Cardio-pulmonary Resuscitation (CPR)
   a. In the event of cardiac or respiratory arrest, every person is presumed to consent to cardiopulmonary resuscitation (CPR), except when:
      - A do not attempt resuscitation order has been issued for that person, OR
      - A completed advance directive for that person is in effect stating the person does not want CPR or their agent determines that the person would not want CPR, OR
      - A person who lacks capacity to make health care decisions is near death and admitted to a health care facility, and the person’s agent is not reasonably available or is not legally capable of making health care decisions for the person, and the attending physician or ARNP, and a concurring second physician, have determined that CPR would be contrary to accepted medical standards and would cause harm to [or cause pain and suffering of] the person, and the attending physician or ARNP has completed a do not attempt resuscitation order, OR
• A person is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner.

19. Issuance of a Do Not Attempt Resuscitation Order (DNR)
   a. All matters pertaining to do not attempt resuscitation orders apply to all persons regardless of whether a person has an advance directive or not.
   b. An attending physician or ARNP may issue a do not attempt resuscitation (DNR) order for a person if the person, or the person’s agent, has consented to the order.
   c. A person may request that his or her attending physician or ARNP issue a do not attempt resuscitation order for himself or herself.
   d. An agent may consent to a do not attempt resuscitation order for a person who lacks the capacity to make health care decisions, if the advance directive signed by the principal grants that authority.
   e. If an agent is not reasonably available and the facility has made diligent efforts to contact the agent without success or the agent is not legally capable of making a decision regarding a do not attempt resuscitation order, an attending physician or ARNP may issue a do not attempt resuscitation order for a person who lacks capacity to make health care decisions. This may only occur if the person is near death and is admitted to a health care facility, and only if a second physician who has personally examined the person concurs with the opinion of the attending physician or ARNP that CPR would be contrary to accepted medical standards and would cause harm or pain and suffering.
   f. If the person is present in a health care facility, the DNR order must be written either on a form consistent with that health care facility’s policy and procedures, on a do not attempt resuscitation card according to the NH state law, or on a medical orders form according to the NH state law.
   g. If the person is not present in a health care facility, the DNR order must be written either on a do not attempt resuscitation card according to the NH state law, or on a medical orders form according to the NH state law.

20. Compliance with a Do Not Attempt Resuscitation Order
    All health care and residential care providers must comply with a DNR order when presented with the order in one of the three forms described above.

21. Protection of Persons Carrying Out in Good Faith a Do Not Attempt Resuscitation Order
    a. No health care provider or residential care provider, or any other person acting for the provider or under the provider’s control, can be held criminally or civilly liable, or be deemed to have engaged in unprofessional conduct, for carrying out an official DNR.
    b. Nobody (including health care providers) who witnesses a cardiac or respiratory arrest can be held criminally or civilly liable for providing cardiopulmonary resuscitation to a person that has a DNR order, only if that person providing the CPR is unaware of the DNR order or believed that the DNR order had been revoked or canceled.
    c. If a physician or ARNP refuses to issue a DNR order or comply with a DNR order because of his or her personal beliefs or conscience, he or she must immediately inform the patient, the patient’s family, or the patient’s agent. The patient, family, or agent may then request a referral to another physician or ARNP.
22. Revocation of a Do Not Attempt Resuscitation Order
   a. A person in a health care facility can revoke his or her DNR order at any time by making either a written, oral, or other act of communication to the attending physician, ARNP, or other professional staff of the facility.
   b. A person in living at home can revoke his or her DNR order at any time by destroying the order and removing any DNR identification on his or her body. The person is responsible for notifying his or her doctor or ARNP.
   c. An agent can revoke a DNR order issued for a principal who is admitted to a health care facility at any time by written notification to the attending physician, ARNP, or other professional staff of the facility, or by oral notification to the attending physician or ARNP in the presence of a witness 18 years of age or older.
   d. An agent can revoke a DNR order issued for a principal who is lives at home at any time by destroying the order and removing any DNR identification on the principal’s body. The agent is responsible for notifying the principal’s doctor or ARNP.
   e. If a DNR order is revoked and the person is in a health care facility, the attending physician or ARNP must immediately cancel the order and notify the staff responsible for that person’s care.
   f. Any staff of a health care facility that is notified of the revocation of a DNR order must immediately inform the attending physician or ARNP.
   g. Notwithstanding the above, only a physician or ARNP can cancel a DNR order.

23. Not Suicide or Murder
   a. While withholding cardiopulmonary resuscitation on a person with a DNR order under the guidelines of the law is never considered murder or suicide, it will not relieve any individual of responsibility for any criminal acts that may have caused the principal’s condition.
   b. Nothing in this law legalizes, condones, authorizes, or approves mercy killing or assisted suicide.

24. Inter-institutional Transfer
   a. If a person with a do not attempt resuscitation order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer must communicate the existence of a DNR order to the receiving facility prior to the transfer. The written portable DNR order, a DNR card, or the medical orders form must accompany the person to the receiving facility and remains effective until a physician at the receiving facility issues admission orders. The DNR card or the medical orders form must be kept as the first page in the person’s transfer records.

25. Do Not Attempt Resuscitation Identification
   a. Do not attempt resuscitation identification can consist of either a medical condition bracelet or necklace with the inscription of the person’s name, date of birth in numerical form and “NH Do Not Resuscitate” or “NH DNR” on it.
   b. DNR identification can be issued only upon presentation of a proper DNR order form, a medical orders form in which a physician or ARNP has documented a DNR order, or a DNR order documented in accordance with a health care facility’s written policy and procedure.
c. A wallet-size portable DNR card may be issued to a person not in a healthcare facility when a physician or ARNP has completed a medical orders form documenting a DNR order.

d. The attending physician or ARNP should document that the patient has been issued portable DNR identification.

1 The contents of this education module summarize NH RSA 137-J. Please refer to the statute for the statutory language.