SEND ORIGINAL PINK FORM WITH PATIENT WHEN TRANSFERRED OR DISCHARGED

PORTABLE DO NOT ATTEMPT RESUSCITATION (P-DNR) ORDER

This is a Physician/Advanced Registered Nurse Practitioner Order Sheet. It is based on patient wishes and medical indications regarding Do Not Attempt Resuscitation (DNR) orders in the event of cardiac or respiratory arrest, as discussed with the patient.

A. Applies only when patient is not breathing or has no pulse. Check box and complete mandatory signature lines in sections A and B.

☐ Do Not Attempt Resuscitation (DNR)

(DNR means: No chest compressions, No intubation, No assisted ventilation, No defibrillation, No pharmacologic resuscitation.)

Last Name of Patient
First Name/Middle Initial of Patient
Patient’s Date of Birth
Last 4 Digits of SSN

Does the patient have a/an:

☐ Durable Power of Attorney for Healthcare? ☐ NO ☐ YES - Document location:_____________________

☐ Living Will? ☐ NO ☐ YES - Document location:_____________________

☐ Organ or Tissue Donation? ☐ NO ☐ YES - Document location:_____________________

☐ Court-appointed Guardian Over the Person? ☐ NO ☐ YES - Document location:_____________________

Patient, Parent of Minor, Durable Power of Attorney for Healthcare or Guardian Information:

Name (Print)                         Signature (Mandatory)
____________________________________________________________________

Address of Parent of Minor, Durable Power of Attorney for Healthcare (DPOAH) or Guardian

Phone Number of Parent, DPOAH or Guardian

Name of Person Preparing Form (Print) (if applicable) Signature of Person Preparing Form Date and Time

SEND ORIGINAL PINK FORM WITH PATIENT WHEN TRANSFERRED OR DISCHARGED

FHC 1/29/07

DO NOT ALTER THIS FORM!

THIS IS YOUR PORTABLE DNR CARD. REMOVE THE CARD BELOW AND KEEP IT ON YOUR PERSON AT ALL TIMES EVEN IF YOU DECIDE TO WEAR A NH-DNR BRACELET.

Portable-DNR

NEW HAMPSHIRE DO NOT ATTEMPT RESUSCITATION ORDER
As this person’s attending physician or ARNP and as a licensed physician or ARNP, I order that this person SHALL NOT BE RESUSCITATED in the event of cardiac or respiratory arrest.

Patient Name (Print) Patient Signature / Date

Physician/ARNP Name (Print) Physician/ARNP Signature / Date

If applicable: Health Care Agent Name (Print) Health Care Agent Signature / Date

Portable-DNR

Patent Address

Physician/ARNP Address

Health Care Agent Address

Patient Phone Number

Physician/ARNP Phone Number

Health Care Agent Phone Number

FHC 1/29/07