



Illinois Department of Public Health

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UNIFORM DO-NOT-RESUSCITATE (DNR) ORDER FORM**Patient Directive**

I, _____, born on _____, hereby direct the following in the event of:
 (print full name) (birth date)

1. FULL CARDIOPULMONARY ARREST (When both breathing and heartbeat stop):

- ☒ **Do Not Attempt Cardiopulmonary Resuscitation (CPR)**
 (Measures to promote patient comfort and dignity will be provided.)

2. PRE-ARREST EMERGENCY (When breathing is labored or stopped, and heart is still beating):**SELECT ONE**

- ☐ **Do Attempt Cardiopulmonary Resuscitation (CPR) -OR-**
☐ **Do Not Attempt Cardiopulmonary Resuscitation (CPR)**
 (Measures to promote patient comfort and dignity will be provided.)

Other Instructions _____

Patient Directive Authorization and Consent to DNR Order (Required to be a valid DNR Order)

I understand and authorize the above Patient Directive, and consent to a physician DNR Order implementing this Patient Directive.

Printed name of individual _____

Signature of individual _____

Date _____

-OR-

Printed name of (circle appropriate title):
 legal guardian
 OR agent under health care power of attorney
 OR healthcare surrogate decision maker

Signature of legal representative _____

Date _____

Witness to Consent (Required to have two witnesses to be a valid DNR Order)

I am 18 years of age or older and have witnessed the giving of consent by the above person.

Printed name of witness _____

Signature of witness _____

Date _____

Printed name of witness _____

Signature of witness _____

Date _____

Physician Signature (Required to be a valid DNR Order)

I hereby execute this DNR Order on _____.
 Today's date

Signature of attending physician _____

Printed Name of attending physician _____

Physician's telephone number _____

◆ Send this form or a copy of both sides with the individual upon transfer or discharge. ◆

**Summarize medical condition:**