Hospice *of* New York

DNR REQUEST FOR ADULT WITH CAPACITY

I, _____, hereby consent to my attending physician issuing a Do Not Resuscitate – DNR – order, in the event that I suffer cardiac or respiratory arrest.

I have been advised by my attending physician and/or the hospice nurse in collaboration with the hospice medical director (or his/her designee) regarding the range of available resuscitation measures, the foreseeable risks and benefits of these measures for me and the consequences of a DNR order.

I understand that this DNR request may be revoked at any time and that it does not prevent me from obtaining other emergency medical services at the direction of my physician.

_____ _____ / / _____

PATIENT'S SIGNATURE DATE

WITNESSES

_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	_____
RELATIONSHIP	RELATIONSHIP
_____ _____ / / _____	_____ _____ / / _____
AGE DATE	AGE DATE

PHYSICIAN CERTIFICATION

These Directives are the expressed wishes of the patient, are medically appropriate, and are documented in the patient's permanent medical record.

_____	_____
SIGNATURE	RELATIONSHIP
_____	_____ / / _____
NYS License Number	DATE