DO NOT RESUSCITATE ORDER

State of Florida, Section 401.45, Florida Statutes

Patient's Full Legal Name: _____ Date of Birth: _____
(Print or Type)

PATIENT'S (OR AUTHORIZED PERSON'S) STATEMENT

Being informed of my right to refuse cardiopulmonary resuscitation (CPR), including artificial ventilation, cardiac compression, endotracheal intubation, and defibrillation, I direct that CPR be withheld or withdrawn from me.

By: _____ Date: _____
(Signature of Patient or Authorized Person)

I, _____, am authorized to sign on the patient's behalf as the patient's
(Print or Type Name of Authorized Person)

☐ principal, ☐ surrogate, ☐ proxy, or ☐ the minor patient's principal (per s. 765.101, F.S.); or I am expressly authorized to make the patient's health care decisions pursuant to a ☐ guardianship (per s. 744.102, F.S.), or ☐ power of attorney (per s. 709.08, F.S.).

HEALTH CARE PROVIDER'S STATEMENT

I, _____, provider license number _____,
(Print Full Legal Name)

am the patient's ☐ physician, ☐ osteopathic physician, ☐ autonomous advanced practice registered nurse, or ☐ physician assistant authorized by law to sign this order. I direct the withholding or withdrawal of CPR from the patient in the event of the patient's cardiac or respiratory arrest.

By: _____ Date: _____ Ph: _____
(Signature of Health Care Provider) (Date Signed) (Emergency)

A copy of this document printed on yellow paper (any shade) is valid as the original.

(Cut Along Line for Wallet Card)

DO NOT RESUSCITATE ORDER

State of Florida
Section 401.45, Florida Statutes

PATIENT'S OR AUTHORIZED PERSON'S STATEMENT

I, _____ , being informed
(Print or Type Full Legal Name and Date of Birth)

of my right to refuse cardiopulmonary resuscitation (CPR), including artificial ventilation, cardiac compression, endotracheal intubation, and defibrillation, direct that CPR be withheld or withdrawn from me.

By:_____ Date: _____
(Signature of Patient or Authorized Person) (Date Signed)

_____
(Print or Type Name of Authorized Person)

I am the patient's ☐ principal, ☐ surrogate, ☐ proxy, or ☐ the minor patient's principal (per s. 765.101, F.S.); or I am expressly authorized to make the patient's health care decisions pursuant to a ☐ guardianship (per s. 744.102, F.S.), or ☐ power of attorney (per s. 709.08, F.S.).

Fold Here

HEALTH CARE PROVIDER'S STATEMENT

I, _____,
(Print or Type Full Legal Name)

provider license number _____, am the patient's ☐ physician, ☐ osteopathic physician, ☐ autonomous advanced practice registered nurse, or ☐ physician assistant authorized by law to sign this order. I direct the withholding or withdrawal of CPR from the patient in the event of the patient's cardiac or respiratory arrest.

By: _____ Date: _____
(Signature of Health Care Provider) (Date Signed)

Phone: _____
(Emergency)

Form DH 1896, Revised 06/2022, Incorporated by Rule 64J-2.018, F.A.C.