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Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

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

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

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

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.* ◆

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Patient's name _____

Summarize medical condition:

When This Form Should Be Reviewed

This DNR order, in effect until revoked, should be reviewed periodically, particularly if –

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

How to Complete the Form Review

1. Review the other side of this form.
2. Complete the following section.
   If this form is to be voided, write "VOID" in large letters on the other side of the form.
   After voiding the form, a new form may be completed.

Date	Reviewer	Location of review	Outcome of Review
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; **no** new form completed
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; **no** new form completed
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; **no** new form completed

Advance Directives

I also have the following advance directives:

- ❑ Health Care Power of Attorney
- ❑ Living Will
- ❑ Mental Health Treatment Preference Declaration

Contact person (name and phone number)

_____

_____

_____

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

IOCI 0741-10

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