

Date: _____

VERIFICATION OF DO NOT RESUSCITATE ORDER

Dear MD/DO/APRN/PA:

Please complete this card and with the permission of the patient, FAX the entire card to the WV e-Directive Registry, then detach at the perforation, give the bottom of the card to the patient, and keep the top in your records.

REGISTRY FAX: 844-616-1415

Last Name/First/Middle Initial: (Print legibly)

Mailing Address:

City/State/Zip:

Date of Birth (mm/dd/yyyy)

_____/_____/_____

Last 4 SSN

Gender

M F

Date: _____

DO NOT RESUSCITATE ORDER

As treating provider of _____

(patient name)

and a licensed MD/DO/APRN/PA, I order that this person **SHALL NOT BE RESUSCITATED** in the event of cardiac or respiratory arrest. This order has been discussed with _____ or his/her representative _____ or his/her surrogate decision maker _____ who has given consent as evidenced by his/her signature below.

MD/DO/APRN/PA Full Name (Printed) _____

MD/DO/APRN/PA Signature _____

Address _____

Person/Surrogate Signature _____

Address _____

Date of Birth (mm/dd/yyyy)

_____/_____/_____

Last 4 SSN

Gender

M F

**If you cancel this DNR Card,
CALL the WV e-Directive Registry at
877-209-8086
so that it can be removed from the Registry.**

**For more information or additional
cards, please contact:**

WV Center for End-of-Life Care
1195 Health Sciences North
P O Box 9022
Morgantown, WV 26506-9022

**877-209-8086
www.wvendoflife.org**

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