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

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

REGISTRY FAX: 844-616-1415