

HOME DNR/DNI REQUEST FORM

(An advanced request by the patient to limit the scope of emergency medical care)

I, _____ request limited emergency care as herein described.

I understand DNR means that if my heart stops beating or if I stop breathing, no medical treatment will be started or continued.

I understand DNI means that if I stop breathing, I will not be placed on an artificial breathing machine.

I understand either or both of these decisions will not prevent me from obtaining emergency medical care by paramedics and other medical care prior to my death at the direction of my physician.

I understand I may revoke these directions at any time.

I give permission for this information to be given to paramedics, doctors, nurses or other health personnel as necessary to implement these directives.

I hereby agree to the "Do Not Resuscitate" order. _____ (initial)

I hereby agree to the "Do Not Intubate" order. _____ (initial)

Patient/proxy signature

date

address

THESE DIRECTIVES ARE THE EXPRESSED WISHES OF THE PATIENT, ARE MEDICALLY APPROPRIATE, AND ARE DOCUMENTED IN THE PATIENT'S PERMANENT MEDICAL RECORD

Do Not Resuscitate (DNR). In the event of an acute cardiac or respiratory arrest no cardiopulmonary resuscitation will be initiated.

Do Not Intubate (DNI). In the event of acute or impending respiratory failure, endotracheal intubation to prevent sustained assisted ventilation shall not be performed. (DNI) does not prohibit emergency management to prevent or reverse acute airway obstruction with oral, nasal, or esophageal obturator airways or treatment of transient respiratory insufficiency with oxygen or short trails of assistec ventilation with positive pressure ventilation equipment or Ambu-bags.)

physician's signature

date

address