# Do Not Resuscitate (DNR) Order

**Core Policy – CP2.12**

<table>
<thead>
<tr>
<th>Distribution: Place in Advanced Directive section of Medical Record</th>
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<tbody>
<tr>
<td>Shands Jacksonville: Place in plastic sleeve in front of the Medical Record</td>
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</table>

**Check all that apply.**

**Date ______________ Time ______________**

**In the event of the patient’s cardiac or respiratory arrest:**

- **□ Do Not Resuscitate** defined as resuscitative efforts including all of the following but not limited to: do not intubate; do not perform CPR; do not defibrillate; do not administer resuscitation medications, including vasoactive drugs and those medications used to treat arrhythmias

**OR**

**Perform only the following procedures:**

- **□ CPR**
- **□ Endotracheal Intubation/Mechanical Ventilation**
- **□ Defibrillation**
- **□ Administer resuscitation medications (Chemical Code)**
- **□ Other (be specific)**

**Patient’s Primary/Attending Physician Name (Please Print)________________________**

**Patient’s Primary/Attending Physician Signature________________________**

**Physician’s Provider Number (if required) ________________________**

**Note: If Verbal/Telephone Order, Patient’s Primary/Attending Physician must promptly authenticate, and date below.**

**Date ______________ Time ______________**

**If Verbal/Telephone Order from Patient’s Primary/Attending Physician:**

**Name of Designated Health Care Provider taking the Order: ________________________**

**Signature of Designated Health Care Provider taking the Order: ________________________**

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**Rescind Do Not Resuscitate Order**

**Date ______________ Time ______________**

**Rescind the above order and Attempt Full Resuscitation Efforts**

**Patient’s Primary/Attending Physician Name (Please Print)________________________**

**Patient’s Primary/Attending Physician Signature________________________**

**Physician’s Provider Number (if required) ________________________**

**Note: If Verbal/Telephone Order, Patient’s Primary/Attending Physician must promptly authenticate, and date below.**

**Date ______________ Time ______________**

**If Verbal/Telephone Order from Patient’s Primary/Attending Physician:**

**Printed Name of Designated Health Care Provider taking the Order: ________________________**

**Signature of Designated Health Care Provider taking the Order: ________________________**

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**Patient Name: ________________________ Patient Identification #: ________________________**