Wellstar HEALTH SYSTEM

Do Not Resuscitate Consent

Patient Name | Date of Birth

Adult Hospice Patient with Decision-Making Capacity:

(Patient completes this section if possible)

I request that no resuscitative measures be initiated upon me to restore cardiac/respiratory function, and I consent to a Do Not Resuscitate Order being entered in my medical record. I understand that this pertains only to the provision of cardiopulmonary resuscitation (CPR) and not to other life-sustaining procedures. I understand that while CPR will not be performed, all other efforts will be made to keep me comfortable. I understand that I may revoke consent at any time.

Patient Signature | Date

Witness Signature of Hospice Team Member | Date

Or

Hospice Patient without Decision-Making Capacity:

(Authorized person completes this section if patient is unable to consent above)

I request that no resuscitative measures be initiated: upon the above-named patient to restore cardiac/respiratory function, and I consent to a Do Not Resuscitate Order being entered in the patient's medical record. I understand that this pertains only to the provision of cardiopulmonary resuscitation (CPR) and not to other life-sustaining procedures. I understand that while CPR will not be performed, all other efforts will be made to keep the patient comfortable. I declare that if the patient is unable to express their own wishes on this matter I am the highest Authorized Person who may consent to this Do Not Resuscitate Order. I understand that I may revoke consent at any time.

In order of priority (check relationship to patient)

- ☐ Healthcare Agent
- ☐ Spouse
- ☐ Court-appointed Guardian
- ☐ Adult Child
- ☐ Adult Sibling
- ☐ Parent

Patient Signature | Date

Witness Signature of Hospice Team Member | Date