Date:_____

VERIFICATION OF DO NOT RESUSCITATE ORDER

Dear Physician:

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 Clearly)

_____

Mailing Address:

_____

City/State/Zip:

_____

Date of Birth (mm/dd/yyyy)

_____/_____/_____

Last 4 SSN

☐☐☐☐

Gender

☐ M ☐ F

Date:_____

DO NOT RESUSCITATE ORDER

As treating physician of _____

(patient name)

and a licensed physician, 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.

Physician Full Name (Printed) _____

Physician 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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