

# State of Florida DO NOT RESUSCITATE ORDER

(please use ink)

Patient's Full Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print or Type Name)

### PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.

(If not signed by patient, check applicable box):

- Surrogate
- Proxy (both as defined in Chapter 765, F.S.)
- Court appointed guardian
- Durable power of attorney (pursuant to Chapter 709, F.S.)

\_\_\_\_\_  
(Applicable Signature) (Print or Type Name)

### PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

\_\_\_\_\_  
(Signature of Physician) (Date) Telephone Number (Emergency)

\_\_\_\_\_  
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2002

### PHYSICIAN'S STATEMENT

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(Signature of Physician) (Date) Telephone Number (Emergency)

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(Print or Type Name) (Physician's Medical License Number)



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