

Resuscitation Orders for Patient: _____

Choose **ONE** of the following:

A. FULL RESUSCITATION WITHOUT LIMITATIONS

B. LIMITED RESUSCITATION:

Provide	Do Not Provide	
<input type="checkbox"/>	<input type="checkbox"/>	Compressions
<input type="checkbox"/>	<input type="checkbox"/>	Intubation
<input type="checkbox"/>	<input type="checkbox"/>	Mechanical Ventilation
<input type="checkbox"/>	<input type="checkbox"/>	Defibrillation/Cardioversion
<input type="checkbox"/>	<input type="checkbox"/>	Medication to treat Life threatening Arrhythmias
<input type="checkbox"/>	<input type="checkbox"/>	Medication to treat Hemodynamic Deterioration

C. DO NOT RESUSCITATE (DNR)/No Code

- No compressions
- No Intubation
- No Medication to treat Life threatening Arrhythmias or Hemodynamic deterioration
- No Mechanical Ventilation
- No Defibrillation / Cardioversion

D. DNR: Continue Current Ventilator and Support

Do not reintubate/ventilate or re-start hemodynamic or arrhythmia medication, if weaned/stopped

OR

DNR: Plan to change ventilator settings as appropriate

E. COMFORT/PALLIATIVE CARE MEASURES

- YES NO Continue tube feeding if already in progress
- ♦ **DNR/ No Code**
- ♦ **All medical interventions not leading to comfort removed or limited**
- ♦ **All measures to assure comfort/pain control and maintain dignity are to be provided**

The basis for these orders is:

- Patient Preference
- Patient's best interest (patient lacks capacity or preferences unknown)
- Medical Indications
- Advance Directive
- Other: _____

Spoke with: _____
(Family/Legal Representative)

Physician Signature

Date / Time

Resuscitation Order / DNR Form

PATIENT IDENTIFICATION

