INSTITUT JANTUNG NEGARA
National Heart Institute

PATIENT'S INFORMATION
(Please Stick Label)

DO NOT RESUSCITATE FORM

Patient's Name: _____

Date: _____

Relation to Patient: _____

I hereby confirm that:

(1) It has been explained to me by _____ that the Patient has become unconscious and/or incapable of exercising rational judgment so that he/she is unable to communicate his/her wishes regarding his/her medical treatment;

(2) The Patient's critical condition has been explained to me and I have been given the opportunity to ask all questions regarding the Patient's condition and all my questions have been answered.

(3) I understand that all life-sustaining medical efforts for the Patient have been exhausted.

In the event of a cardiorespiratory arrest, I agree to allow natural death.

I understand this decision **WILL NOT** prevent the Patient from receiving other medical care, including palliative treatment for pain, breathing difficulties, bleeding, or other medical conditions.

I understand I may **revoke** my decision at any time by informing the relevant healthcare professional.

Signature: .....
Name : .....
Relation to Patient: .....
NRIC number: .....
Date: .....

Signature: .....
Name of Doctor: .....
Designation: .....
NRIC number: .....
Date: .....

Signature: .....
Name of Witness: .....
Relation to Patient : .....
NRIC number: .....
Date: .....

Effective Date: 15 January 2020