

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMERGENCY MEDICAL SERVICES PREHOSPITAL
DO NOT RESUSCITATE (DNR) FORM**

REFERENCE NO. 815.1



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**EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM**

An Advance Request to Limit the Scope of Emergency Medical Care



I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Legally Recognized Health Care Decisionmaker Signature

Date

Legally Recognized Health Care Decisionmaker's Relationship to Patient

By signing this form, the legally recognized health care decisionmaker acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

I affirm that this patient/legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician Signature

Date

Print Name

Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

White Copy: To be kept by patient

Yellow Copy: To be kept in patient's permanent medical record

Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381

EFFECTIVE: 06-01-92
REVISED: 07-01-24
SUPERSEDES: 04-01-21

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