PREHOSPITAL MEDICAL CARE DIRECTIVE
(DO NOT RESUSCITATE or DNR)

(IMPORTANT – THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

MAKE SURE YOU DISPLAY THIS FORM AS VISIBLY AS POSSIBLE FOR FIRST RESPONDERS

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain.

You can either attach a picture to this form OR complete the personal information.

Please take the time to fill out a Health Care Power of Attorney form. That way, if you are unable to communicate your wishes, your agent can sign this form on your behalf, if that is your wish.

This form must be signed by you, in front of your witness or notary. Your Health Care Provider and your witness or notary must also sign this form.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

IMPORTANT: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

PREHOSPITAL MEDICAL CARE DIRECTIVE

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient's Printed Name: ____

Patient's Signature: ____Date: ________________

***If I am unable to communicate my wishes, and I have designated a Health Care Power of Attorney, my elected Health Care agent shall sign:**

Health Care Power of Attorney Printed Name: ____

Health Care Power of Attorney Signature: ____

PROVIDE THE FOLLOWING INFORMATION OR ATTACH A RECENT PHOTO:

Date of Birth______________
Sex_____________________
Race____________________
Eye Color ________________
Hair Color _______________

INFORMATION ABOUT MY DOCTOR AND HOSPICE (if I am in Hospice)**:**

Physician:____Telephone: __________________
Hospice Program, if applicable (name):____

SIGNATURE OF DOCTOR OR OTHER HEALTH CARE PROVIDER (REQUIRED)

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider: ____
Date: __________________

SIGNATURE OF WITNESS OR NOTARY (NOT BOTH)

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Witness Signature:____Date: ________________

NOTARIAL JURAT:

STATE OF ARIZONA) ss
COUNTY OF _______________)

____
Patient's Name/Health Care Power of Attorney Name

Subscribed and sworn (or affirmed) before me this _______________ day of ___________, 20 ______

Notary Public Signature: ______________________________My Commission Expires: _____________