

Do Not Resuscitate (DNR) Form

This is an important document. We recommend that you discuss this form with a doctor, but you do not have to.

Your personal details:

Your name:

Your address:

- I request limited emergency care as herein described.
- 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 health care professionals prior to my death.
- I give permission for this information to be available to local hospitals, out of hours and emergency services or other healthcare professionals as necessary to implement this directive.
- I hereby agree to the 'Do Not Resuscitate' (DNR) order.
- This directive remains effective until I make clear that my wishes have changed.

Signatures:

Sign and date the form here in the presence of a witness

Your signature:

Date:

The witness must sign here after you have signed the form.
The witness should then print his or her name and address in the spaces provided and complete the declaration below.

Signature of witness:

Name of witness:

Address :

Declaration of witness

The capacity in which I know the patient:

I confirm that I am not the patient's spouse/relative or healthcare representative and will not benefit personally from the patient's death (tick box)