OKLAHOMA DO-NOT-RESUSCITATE (DNR) CONSENT FORM

I, _____, request limited health care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;

3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification of a physician or other health care provider of the health care agency or by oral notification of my attending physician; or

4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

_____OR_____

Signature of Person Signature of Representative

(Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Rights of the Terminally III or Persistently Unconscious Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)

This DNR consent form was signed in my presence.

_____	_____	_____
Date	Signature of Witness	Address
	_____	_____
	Signature of Witness	Address

CERTIFICATION OF PHYSICIAN

(This form is to be used by an attending physician only to certify that an incapacitated person without a representative would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. An attending physician of an incapacitated person without a representative must know by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that such person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Clear and convincing evidence for this purpose shall include oral, written, or other acts of communication between the patient, when competent, and family members, health care providers, or others close to the patient with knowledge of the patient's desires.)

I hereby certify, based on clear and convincing evidence presented to me, that I believe that would not have consented to the Name of Incapacitated Person adminstration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Therefore, in the event of cardiac or respiratory arrest, no chest compressions, artificial ventilation, intubations, defibrillation, or emergency cardiac medications are to be initiated.

_____ _____

Physician's Signature/Date Physician's Name (PRINT)

_____

Physician's Address/Phone

Witnesses must be individuals who are eighteen (18) years of age or older who are not legatees, devisees or heirs at law.

It is the intention of the Legislature that the preferred, but not required, do-not-resuscitate form in Oklahoma shall be the form set out in subsection B of this section.