Patient Name:_____ Pt. #_____

DNR IDENTIFICATION FORM

☐ **DNRCC**
(If this box is checked the DNR Comfort Care Protocol is activated immediately.)

☐ **DNRCC-Arrest**
(If this box is checked, the DNR Comfort Care Protocol is implemented in the event of a cardiac arrest or a respiratory arrest.)

Patient Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Birthdate:_____ Gender ☐ M ☐ F

Signature_____ (optional)

Certification of DNR Comfort Care Status (to be completed by the physician)*

(Check only one box)
☐ **Do-Not-Resuscitate Order** - My signature below constitutes and confirms a formal order to emergency medical services and other health care personnel that the person identified above is to be treated under the State of Ohio DNR Protocol. I affirm that this order is not contrary to reasonable medical standards or, to the best of my knowledge, contrary to the wishes of the person or of another person who is lawfully authorized to make informed medical decisions on the person's behalf. I also affirm that I have documented the grounds for this order in the person's medical record.

☐ **Living Will (Declaration) and Qualifying Condition** - The person identified above has a valid Ohio Living Will (declaration) and has been certified by two physicians in accordance with Ohio law as being terminal or in a permanent unconscious state, or both.

Printed name of physician*:_____

Signature_____ Date:_____

Address:_____ Phone:_____

City/State:_____ Zip:_____

* A DNR order may be issued by a certified nurse practitioner or clinical nurse specialist when authorized by section 2133.211 of the Ohio Revised Code.

Form #CLIN002 Rev. 11/16

White – Medical Records Yellow – Nursing Home/Facility Based/Pt Home