Durable Do Not Resuscitate Order
Virginia Department of Health

Patient’s Full Legal Name _____________________________________________ Date _______________

Physician’s Order
I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient’s medical record that he/she or a person authorized to consent on the patient’s behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a “Person Authorized to Consent on the Patient’s Behalf” with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of “Person Authorized to Consent on the Patient’s Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of “Person Authorized to Consent on the Patient’s Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient’s cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

__________________________________________  ____________________________  ____________________________
Physician’s Printed Name  Physician’s Signature  Emergency Phone Number

__________________________________________
Patient’s Signature

__________________________________________
Signature of Person Authorized to Consent on the Patient’s Behalf

Copy 1 – To be kept by patient
Durable Do Not Resuscitate Order

Virginia Department of Health

Patient’s Full Legal Name ___________________________________________ Date __________________

Physician’s Order

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____________________________  _________________________  _________________________
Physician’s Printed Name       Physician’s Signature       Emergency Phone Number

____________________________  _________________________
Patient’s Signature             Signature of Person Authorized to Consent on the Patient’s Behalf

Copy 2 – To be kept in patient’s permanent medical record
Durable Do Not Resuscitate Order
Virginia Department of Health

Patient’s Full Legal Name ___________________________________________ Date ______________

Physician’s Order
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_____________________________________________  _______________________________  _______________________________
Physician’s Printed Name           Physician’s Signature            Emergency Phone Number

_____________________________________________  _______________________________________
Patient’s Signature           Signature of Person Authorized to Consent on the Patient’s Behalf

Copy 3 – Used to order DDNR jewelry            EMS – 7105  6/2011