DO NOT RESUSCITATE (DNR)
ORDER

Print Patient's Full Name: _____

In the event that my heart stops, I do not wish to be resuscitated. I am signing this DO NOT RESUSCITATE order after discussion with my physician, Dr. Eko-Isenalumhe, and I understand the full implications.

I, the undersigned patient, or agent with a durable power of attorney for health care, direct that cardiopulmonary resuscitation should not be initiated. I understand that I may revoke these directions at any time.

_____ _____
Signature of Witness **Signature of Patient**

_____ _____
Printed Name of Witness **Printed Name of Patient**

_____ _____
Date **Signature of Doctor**

_____
Printed Full Name of Person Acting with durable power of attorney for Health Care

I, _____, herby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decision for me. The includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ **Relation**: _____

Home Phone: _____ **Other Phone**: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decision for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ **Relation**: _____

Home Phone: _____ **Other Phone**: _____

Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPPA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

SIGNATURE

Your signature must Either be witnessed by two competent adults (Block A) or by a notary public (Block B).

Signature: _____ **Date**: _____
Patient

BLOCK A: Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not names as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not names as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

BLOCK B: You may choose to have your signature witnessed by a notary public instead of the witness described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally know to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

_____ _____

My Commission Expires Signature of Notary Public

_____ _____

Date Signature of Attending Physician

_____

Printed Name of Attending Physician

THIS ORDER REMAINS IN EFFECT UNTIL THE DEATH OF THE PATIENT OR DOCUMENT IS DESTROYED