## State of Illinois

# Do Not Resuscitate (DNR) Order

**I, _____ ,** (print full name) **DO NOT AUTHORIZE CARDIOPULMONARY RESUSCITATION.** I (or my legal representative) understand that this order remains in effect until revoked by me (or my legal representative) or the attending physician. I (or my legal representative) acknowledge that cardiopulmonary resuscitation (CPR) will not be performed if breathing or heart beat stops. (The signatures of [a] the patient **OR** legal representative, [b] the physician and [c] two witnesses are required.)

| _____ | _____ | _____ |
|---|---|---|
| Printed name of patient | Signature of patient | Date |
| _____ | _____ | _____ |
| Printed name of physician | Signature of physician | Date |

_____

Effective date

| _____ | _____ | _____ |
|---|---|---|
| Printed name of witness | Signature of witness | Date |

_____

Address of witness

| _____ | _____ | _____ |
|---|---|---|
| Printed name of witness | Signature of witness | Date |

_____

Address of witness

### Legal Representative's Signature of Consent for Patient Lacking Decision Making Capacity

(If the patient lacks decision making capacity, then a signature in this section is required.)

_____

Printed name of (circle appropriate title) legal guardian
**OR** durable power of attorney for health care agent
**OR** surrogate decision maker

_____

Street Address

_____

City, State, ZIP

_____

Signature of legal representative

_____

Date

**Illinois Department of Public Health**
535 W. Jefferson St.
Springfield, IL 62761
217-785-2080,
TTY (hearing impaired use only)
800-547-0466

**Reproduce on brightly colored orange paper**