DO-NOT-RESUSCITATE • DNR •		(Page 1 d
Illinois Department of		
UNIFORM DO-N	OT-RESUSCITATE (DNR) AI	JVANCE DIRECTIVE
Patient Directive		
	hom on how by the	act the following in the surget
I,(print full name)	_, born on, hereby dir (birth date)	eor the following in the event o
1. FULL CARDIOPULMONARY	ARREST (When both breathing ar	nd heartbeat stop):
•	opulmonary Resuscitation (CPR) at comfort and dignity will be provided.)	
2. PRE-ARREST EMERGENCY	(When breathing is labored or stop	ped, and heart is still beating
SELECT ONE		
Do Attempt Cardiopuli	monary Resuscitation (CPR) -OR-	
•	opulmonary Resuscitation (CPR)	
	t comfort and dignity will be provided.)	
Other Instructions		
	<b>d Consent to DNR Order</b> (Required to above Patient Directive, and consent to a	
ing this Patient Directive.		
ing this Patient Directive.	above Patient Directive, and consent to a	physician DNR Order implement
ing this Patient Directive. Printed name of individual -OR-	above Patient Directive, and consent to a	physician DNR Order implement
ing this Patient Directive. Printed name of individual -OR- Printed name of (circle appropriate title): legal guardian	above Patient Directive, and consent to a	Date
ing this Patient Directive. Printed name of individual -OR- Printed name of (circle appropriate title): legal guardian OR agent under health care power of attorney	above Patient Directive, and consent to a	Date
ing this Patient Directive. Printed name of individual -OR- Printed name of (circle appropriate title): legal guardian OR agent under health care power of attorney OR healthcare surrogate decision maker	above Patient Directive, and consent to a           Signature of individual           Signature of legal representative	Date
ing this Patient Directive. Printed name of individual -OR- Printed name of (circle appropriate title): legal guardian OR agent under health care power of attorney OR healthcare surrogate decision maker Witness to Consent (Required to have	above Patient Directive, and consent to a           Signature of individual           Signature of legal representative	Date
ing this Patient Directive. Printed name of individual -OR- Printed name of (circle appropriate title): legal guardian OR agent under health care power of attorney OR healthcare surrogate decision maker Witness to Consent (Required to have	above Patient Directive, and consent to a Signature of individual Signature of legal representative two witnesses to be a valid DNR Order)	Date
ing this Patient Directive. Printed name of individual -OR- Printed name of (circle appropriate title): legal guardian OR agent under health care power of attorney OR healthcare surrogate decision maker Witness to Consent (Required to have I am 18 years of age or older an	above Patient Directive, and consent to a Signature of individual Signature of legal representative two witnesses to be a valid DNR Order)	Date
ing this Patient Directive. Printed name of individual -OR- Printed name of (circle appropriate title): legal guardian OR agent under health care power of attorney OR healthcare surrogate decision maker Witness to Consent (Required to have I am 18 years of age or older an Printed name of witness	above Patient Directive, and consent to a Signature of individual Signature of legal representative two witnesses to be a valid DNR Order) ad have witnessed the giving of consent to Signature of witness	by the above person.
ing this Patient Directive.  Printed name of individual -OR- Printed name of (circle appropriate title): legal guardian OR agent under health care power of attorney OR healthcare surrogate decision maker  Witness to Consent (Required to have I am 18 years of age or older an Printed name of witness	above Patient Directive, and consent to a Signature of individual Signature of legal representative two witnesses to be a valid DNR Order) and have witnessed the giving of consent b	physician DNR Order implement Date Date Date by the above person.
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## (Page 2 of 2) Illinois Department of Public Health **UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE**

Patient's name

Summarize medical condition:

## When This Form Should Be Reviewed

This DNR order, in effect until revoked, should be reviewed periodically, particularly if -

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

## How to Complete the Form Review

- 1. Review the other side of this form.
- 2. Complete the following section. If this form is to be voided, write "VOID" in large letters on the other side of the form. After voiding the form, a new form may be completed.

Date       Reviewer       Location of review       Outcome of Review <ul> <li>No change</li> <li>FORM VOIDED; no new form completed</li> <li>FORM VOIDED; no new form completed</li> </ul> Date       Reviewer       Location of review       Outcome of Review       No change         Date       Reviewer       Location of review       No change       No change       No change         Date       Reviewer       Location of review       No change       No change       No change       No change         Date       Reviewer       Location of review       No change       No change <t< th=""><th><u>Date</u></th><th><u>Reviewer</u></th><th>Location of review</th><th>Outcome of ReviewNo changeFORM VOIDED; new form completedFORM VOIDED; no new form completed</th></t<>	<u>Date</u>	<u>Reviewer</u>	Location of review	Outcome of ReviewNo changeFORM VOIDED; new form completedFORM VOIDED; no new form completed			
<ul> <li>No change</li> <li>FORM VOIDED; new form completed</li> <li>FORM VOIDED; no new form completed</li> <li>Advance Directives</li> <li>I also have the following advance directives:</li> <li>Contact person (name and phone number)</li> <li>Health Care Power of Attorney</li> <li>Living Will</li> <li>Mental Health Treatment Preference Declaration</li> <li>Send this form or a copy of both sides with the individual upon transfer or discharge.</li> </ul>	<u>Date</u>	<u>Reviewer</u>	Location of review	<ul><li>No change</li><li>FORM VOIDED; new form completed</li></ul>			
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<ul> <li>Health Care Power of Attorney</li> <li>Living Will</li> <li>Mental Health Treatment Preference Declaration</li> <li>Send this form or a copy of both sides with the individual upon transfer or discharge.</li> </ul>	Advance Directives						
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