Do-Not-Resuscitate (DNR) Palliative Care Consent

Patient Name

Date of Birth

Medical Record Number

Statement of Consent

I, the undersigned, acknowledge that I have discussed with my healthcare provider the options and consequences concerning resuscitation in the event of cardiac or respiratory arrest. I understand the nature of my illness and the palliative care approach to my treatment.

☐ **I consent to a Do-Not-Resuscitate (DNR) order.**

Specific Wishes / Additional Information

Date

Patient/Authorized Representative Signature

Healthcare Provider Signature