

OKLAHOMA DEPARTMENT OF CORRECTIONS
Do Not Resuscitate Consent Form

I, _____ DOC # _____,

request limited health care as described in this document. If my heart stops beating, or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider, including but not limited to emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

I understand that I may revoke this consent at any time, in writing or by telling the physician or other health care provider or witness, regardless of my physical or mental condition.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a Do Not Resuscitate Order.

Signature of Patient

Date

OR

Signature of Health Care Proxy-Acting under the Oklahoma Rights
of the Terminally Ill or Persistently Unconscious Act

Date

This DNR form was signed in my presence.

Signature of Witness _____

Date _____

Address: _____

Signature of Witness _____

Date _____

Address: _____