



TEXAS DEPARTMENT OF HEALTH STANDARD OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDER



This document becomes effective immediately on the date of execution. It remains in effect until the death of the patient or the document is revoked.

1. Patient's full legal name — printed or typed Date of Birth: Male/Female (Circle One)

2. COMPLETE ONE OF THE FOLLOWING THREE BOXES: A, B, OR C.

A. Patient's Statement: I, the undersigned, am capable of making an informed decision regarding the withholding or withdrawing of CPR, including the treatments listed below, and I direct that none of the following resuscitation measures be initiated or continued. Cardiopulmonary resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation

I understand that I will be given comfort measures as needed. I understand that I may revoke this order at any time.

Signature Date Printed or Typed Name

B. Only use this box if the order is being completed by a person acting on behalf of a patient who is incompetent or otherwise unable to make his or her wishes known

I am the patient's: legal guardian; agent under Medical Power of Attorney; managing conservator; Qualified Relative (see back); or parent of a minor child AND:

- I attest to issuance of an Out-of-Hospital DNR by the patient by nonwritten means of communication; OR
I am acting under the guidance of a prior Directive to Physicians; OR
I am acting upon the known values and desires of the patient; OR
I am acting in the patient's best interest based upon the guidance given by the patient's physician.

I direct that none of the following resuscitation measures be initiated or continued; Cardiopulmonary resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation on behalf of the patient.

Signature Date Printed or Typed Name

C. Only use this box only if the order is being completed by two physicians acting on behalf of a patient who is incompetent or otherwise unable to make his or her wishes known, and who is without a legal guardian, agent, managing conservator, qualified relative, or parent.

- I attest to issuance of an Out-of Hospital DNR by the patient by nonwritten communication; OR:
The patient's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgement, considered ineffective in these circumstances or are otherwise not in the best interest of the patient.

I direct that none of the following resuscitation measures be initiated or continued; Cardiopulmonary resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation on behalf of the patient.

Signature Treating Physician Date Printed or Typed Name

Signature Second Physician who is not involved in treating the patient Date Printed or Typed Name

3. WITNESSES: (see qualifications on reverse) We have witnessed all of the above signatures

Witness 1 Signature Date Witness Printed or Typed Name

Witness 2 Signature Date Witness Printed or Typed Name

4. PHYSICIAN'S STATEMENT: I, the undersigned, am the attending physician of the patient named above. I have noted the existence of this order in the patient's medical records, and I direct out-of-hospital health care professionals to comply with this order as presented.

Physician's signature License number

Printed or Typed name Date

ALL PERSONS WHO SIGNED MUST SIGN HERE: This document has been properly completed.

Signature of Patient, Agent or Relative (A or B) Signature of Second Physician (C)

Signature of Witness Signature of Witness

Signature of Attending Physician Date

SHOULD TRANSPORT OCCUR, THIS DOCUMENT OR A COPY MUST ACCOMPANY THE PATIENT.

## OUT-OF-HOSPITAL DNR INSTRUCTIONS

### **PURPOSE:**

This form was designed to comply with the requirements as set forth in Chapter 166 of the Health and Safety Code (H&SC) relating to the issuance of Out-of-Hospital Do-Not-Resuscitate (DNR) orders for the purpose of instructing Emergency Medical Personnel and other health care professionals to forgo resuscitation attempts and to permit the patient to have a natural death with peace and dignity. This order does NOT affect the provision of other emergency care including comfort care.

### **APPLICABILITY:**

This form applies to all health care professionals operating in any out-of-hospital setting to include hospital outpatient or emergency departments and physician's offices.

### **IMPLEMENTATION:**

Any competent individual may execute or issue an Out-of-Hospital DNR Order. The patient's attending physician will document the existence of the directive in the patient's permanent medical record.

If the patient is capable of providing informed consent for the order, he/she will sign and date the out-of-hospital DNR order on the front of this sheet in Box A. In the event that the patient is unable to provide informed consent, his/her Legal Guardian, agent under Medical Power of Attorney, Managing Conservator, Qualified Relative, or Parent (if a minor) may execute the order by signing and dating the form in Box B. If the patient is unable to provide informed consent and none of the persons listed in Box B are available, the treating physician may execute the order with the consent of a second physician who is not treating the patient and/or is a member of the health care facility ethics committee or other medical committee (Box C).

The form must be signed and dated by two witnesses except when executed by two physicians only (Box C).

The original standard Texas Out-of-Hospital DNR form must be completed and properly executed. Duplicates may be made by the patient, health care provider organization or attending physician as necessary. **Copies of this completed document may be used for any purpose that the original may be used and shall be honored by responding health care professionals.**

The presence of a Texas DNR identification device on a person is sufficient evidence that the individual has a valid Out-of-Hospital DNR Order. Therefore, either the original standard form, a copy of the completed standard form, or the device is sufficient evidence of the existence of the order.

For information on ordering identification devices or additional forms, contact the Texas Department of Health at (512) 834-6700.

### **REVOCATION:**

The Out-of-Hospital Do-Not-Resuscitate Order may be revoked at ANY time by the patient **OR** the patient's Legal Guardian/ Agent/Managing Conservator/ Qualified Relative, Parent (if a minor), or physician who executed the order. The revocation may involve the communication of wishes to responding health care professionals, destruction of the form, or removal of all or any Do-Not-Resuscitate identification devices the patient may possess.

**AUTOMATIC REVOCATION:** This Out-of-Hospital DNR order is automatically revoked if the patient is known to be pregnant or in the case of unnatural or suspicious circumstances.

### **DEFINITIONS:**

**Attending Physician:** The physician who is selected by or assigned to a patient who has primary responsibility for a person's treatment and care and is licensed by the Texas State Board of Medical Examiners or who is properly credentialed and holds a commission in the uniformed services of the United States and who is serving on active duty in this state. **(H&SC 166.002 (3) & (12))**

**Qualified Relatives:** Those persons authorized to execute or issue an out-of-hospital DNR order on behalf of a person who is comatose, incompetent, or otherwise mentally or physically incapable of communication under Section 166.088 H&SC Section 166.088 refers to 166.039: "One person, if available, from one of the following categories, in the following priority...: (1) The patient's spouse; (2) the patient's reasonably available adult children; (3) the patient's parents; or (4) the patient's nearest living relative."

**Health Care Professional:** Means physicians, nurses, physician assistants and emergency medical services personnel; and, unless the context requires otherwise, includes hospital emergency department personnel. (H&SC 166.081 (5))

**Witnesses:** Two competent adult witnesses must sign the form acknowledging the signature of the patient or the person(s) acting on the patient's behalf (except when signed by two physicians in Section C). Witness One must meet the qualifications listed below. Witness Two may be any competent adult. Witness One (the "qualified" witness) may not be: (1) person designated to make a treatment decision for the patient; (2) related to the patient by blood or marriage; (3) entitled to any part of the estate; (4) be a person who has a claim against the estate of the patient; (5) the attending physician or an employee of the attending physician; (6) an employee of a health care facility in which the patient is being cared for, if he or she is involved in providing direct patient care to the patient; or (7) an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or any parent organization of the health care facility.

*Please report any problems with this form to the Texas Department of Health at (512) 834-6700.*

Revised May 17, 2000  
Texas Department of Health