

Confirmation of No Do Not Resuscitate (DNR) Order

Date:

Patient Name:

Date of Birth:

Medical Record Number:

This document confirms that, as of the date above, there is **no Do Not Resuscitate (DNR)** order in place for the above-named patient. All appropriate resuscitative measures should be initiated in the event of a cardiac or respiratory arrest.

Physician Name:

Physician Signature:

Date Signed: