Medical Group of North County, Inc.

SAN DIEGO CANCER CENTER

910 Sycamore avenue, #270, Vista, California 92081 • Phone (760) 598-1776 • Fax (760) 598-1704

Internal Medicine: Stuart B. Kipper, M.D., Mary D. Jaramillo, M.D., Neil D. Levine, M.D., M.P.H., F.A.C.P., Charles E. Hergesheimer, M.D., Karen Cadman, M.D., Sam Baroudi, M.D., Loren Novak, D.O.
Hematology/Oncology: Mark J. Adler, M.D., Daniel Vicario, M.D., Rupa Subramanian, MD, Lynette Cederquist, MD

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR)
AN ADVANCE REQUEST TO LIMIT THE SCOPE OF EMERGENCY MEDICAL CARE

I, _____, request limited emergency care as herein described.

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand that this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Date

_____ _____
Surrogate's Relationship to Patient Patient's Medical Record #

_____ _____ _____
Witness Signature Print Name Date

I affirm this directive is the expressed wish of the patient/surrogate, is medically appropriate, and a copy of this form is in the patient's permanent medical record.

In the event of a cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician's Signature Date

_____
Print Name

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY.