CCFORM 9/2006



MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH OFFICE OF EMERGENCY MEDICAL SERVICES

COMFORT CARE / DO NOT RESUSCITATE ("DNR") ORDER VERIFICATION

PATIENT'S LAST NAME				
PATIENT'S FIRST NAME	PATIENT'S MIDDLE NAME OR INITIAL			
DATE OF BIRTH (MM/DD/YYYY) GENDER M F	l L			
STREET OR RESIDENTIAL ADDRESS				
CITY		STATE	ZIP CODE (5 or	9 digits)
LAST NAME OF GUARDIAN OR HEALTH CARE AGENT (If applicable)				
FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT	MIDDLE NAME OR INITIAL			
PATIENT/GUARDIAN/HHEALTH CARE AGENT STATEMENT (SIGNATURE AND DA I ([verify that the above named patient has a current and valid Do Not Resuscitate order ("Deform, the DNR order, if current and valid, will be recognized in out-of-hospital settings an Order Verification Protocol will be followed by emergency medical services personnel."		and that by	signing this	
Signature of Patient/Guardian/Health Care Agent		Date)	
Signature of Patient/Guardian/Health Care Agent PHYSICIAN / NURSE PRACTICIONER (NP) / PHYSICIAN ASSISTANT (PA) VERIFICA ALWAYS REQUIRED) I am an attending physician / NP / PA for the above named patient. I verify that the above order, issued on This DNR order	e named patient has a e is an expiration date, usetts Department of F	NP / PA SI a current ar it is indica	GNATURE AND D nd valid Do Not Re ted below, and this	suscitate
PHYSICIAN / NURSE PRACTICIONER (NP) / PHYSICIAN ASSISTANT (PA) VERIFICA ALWAYS REQUIRED) I am an attending physician / NP / PA for the above named patient. I verify that the above order, issued on This DNR order	e named patient has a e is an expiration date, usetts Department of F d to the above named	NP / PA SI a current an it is indica Public Heal patient. Expirat	GNATURE AND D and valid Do Not Re ated below, and this th, Office of Emerg	suscitate gency Medical f DNR Order
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