

## APPENDIX 2

# State of Illinois Do Not Resuscitate (DNR) Order

I, \_\_\_\_\_, (print full name) **DO NOT AUTHORIZE CARDIOPULMONARY RESUSCITATION.** I (or my legal representative) understand that this order remains in effect until revoked by me (or my legal representative) or the attending physician. I (or my legal representative) acknowledge that cardiopulmonary resuscitation (CPR) will not be performed if breathing or heart beat stops. (The signatures of [a] the patient **OR** legal representative, [b] the physician and [c] two witnesses are required.)

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of physician

\_\_\_\_\_  
Signature of physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Effective date

\_\_\_\_\_  
Printed name of witness

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of witness

\_\_\_\_\_  
Printed name of witness

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of witness

### Legal Representative's Signature of Consent for Patient Lacking Decision Making Capacity

(If the patient lacks decision making capacity, then a signature in this section is required.)

\_\_\_\_\_  
Printed name of (circle appropriate title) legal guardian  
**OR** durable power of attorney for health care agent  
**OR** surrogate decision maker

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Signature of legal representative

\_\_\_\_\_  
Date



**Illinois Department of Public Health**

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