

**Newaygo County Medical Control Authority
DO NOT RESUSCITATE ORDER**

I have discussed my health status with my physician, _____. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order is effective until I revoke it. I am aware that I can revoke this order at any time by simply expressing my request verbally or in writing to my care taking family, physician, or designated patient advocate.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

(Declarant's signature) _____
(Date)

(Type or print declarant's full name)

(Signature of person who signed for declarant, if applicable) _____
(Date)

(Type or print full name)

(Physician's signature) _____
(Date)

(Type or print physician's full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

(Witness signature) (Date) _____
(Witness signature) _____
(Date)

(Type or print witness's name) _____
(Type or print witness's name)

**This form was prepared pursuant to, and is in compliance with,
the "Michigan Do-Not-Resuscitate Procedure Act".**

COBRA NOTICE AND WAIVER

Patient's Name: _____

I, the undersigned, intend and desire that the NEWAYGO COUNTY EMERGENCY MEDICAL SERVICES

DO NOT RESUSCITATE ORDER which I have signed and established shall be honored and adhered to by those individuals providing services within the hospital Emergency Department as well as the pre-hospital emergency medical services personnel who may be transporting me to the hospital Emergency Department. I understand that, pursuant to Federal Law, hospitals that provide such emergency medical services are required to perform a screening examination and provide such emergency medical treatment as necessary to stabilize a patient's emergency medical condition to all persons who present or are presented to the hospital Emergency Department without regard to the person's insurance status or ability to pay for the required examination and treatment.

In making my application for pre-hospital limited treatment, I hereby acknowledge my intent to withhold my consent or refuse to consent to the performance by hospital emergency department personnel, of any such screening examination or provision of appropriate medical treatment necessary to stabilize my emergency medical condition as may otherwise be required under Federal Law. I intend that this withholding/refusal of consent to such examination and treatment be applicable to and equally binding upon those pre-hospital emergency medical service personnel who are responding to my request for limitation of patient care services while transporting me to the hospital as well as those hospital emergency department physicians and other medical personnel that respond to my request when or if I am ultimately presented to the hospital Emergency Department.

I understand that my expression of intent to forego such a screening examination and provision of stabilizing treatment is subject to being changed/reversed if I so desire and that, therefore, if I, or a legally responsible person on my behalf, request performance of a screening examination and provision of necessary stabilizing treatment upon my presentment to the hospital Emergency Department, such examination and treatment will be provided to me, subject to the clinical judgment of the Emergency Department personnel responding to my presentment.

Date Patient's signature or signature of Medical
Durable Power of Attorney or Legal Guardian

Date Witness

**TAKE THIS FORM WITH YOU TO THE EMERGENCY DEPARTMENT IF
YOU HAVE TO GO.**