OKLAHOMA DEPARTMENT OF CORRECTIONS
Do Not Resuscitate Consent Form

I,____ ODOC #___________________________________,

request limited health care as described in this document. If my heart stops beating, or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider, including but not limited to emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

Notification of Activation for a Living Will/Advance Directive and/or DNR (DOC 140138B) will never be honored in situations of self-harm or assault.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;
2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;
3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification to a physician or other health care provider of the health care agency or by oral notification to my attending physician; or
4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

____ _________________
Signature of Patient Date

OR

____ __________________
Signature of Health Care Proxy-Acting under the Oklahoma Advance Directive Act and the Oklahoma Do-Not Resuscitate Act Date

This DNR form was signed in my presence.

Signature of Witness_____________________________________ Date___________

Address:____

Signature of Witness_____________________________________ Date___________

Address:____