

Date: _____

**VERIFICATION OF
DO NOT RESUSCITATE ORDER**

Dear Physician:

Please complete this card, FAX to the WV e-Directive Registry, detach at the perforation, give the bottom of the card to the patient, keep the top in your records.

REGISTRY FAX: 304-293-7442

Last Name/First/Middle Initial: _____

Address: _____

City/State/Zip: _____

Date of Birth (mm/dd/yyyy) _____

Last 4 SSN

Gender

M F

Date: _____

DO NOT RESUSCITATE ORDER

As treating physician of _____
and a WV licensed physician, I order that this person
SHALL NOT BE RESUSCITATED in the event
of cardiac or respiratory arrest. This order has been
discussed with _____
or his/her representative _____
or his/her surrogate decision maker _____
who has given consent as evidenced by his/her
signature below.

Physician Name _____

Physician Signature _____

Address _____

Person/Surrogate Signature _____

Address _____

Date of Birth (mm/dd/yyyy) _____

Last 4 SSN

Gender

M F

WV DO NOT RESUSCITATE

**For more information or additional
forms, please contact:**

WV Center for End-of-Life Care
1195 Health Sciences North
P O Box 9022
Morgantown, WV 26506-9022

877-209-8086
www.wvendofflife.org