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	

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 DATE REQUIRED)

I _____ (☐patient ☐ guardian ☐health care agent) verify that the above named patient has a current and valid Do Not Resuscitate order ("DNR order"). I understand that by signing this form, the DNR order, if current and valid, will be recognized in out-of-hospital settings and the COMFORT CARE / Do Not Resuscitate Order Verification Protocol will be followed by emergency medical services personnel.

Signature of Patient/Guardian/Health Care Agent _____ Date _____

PHYSICIAN / NURSE PRACTICIONER (NP) / PHYSICIAN ASSISTANT (PA) VERIFICATION (PHYSICIAN / NP / PA SIGNATURE AND DATES ALWAYS REQUIRED)

I am an attending physician / NP / PA for the above named patient. I verify that the above named patient has a current and valid Do Not Resuscitate order, issued on _____

This DNR order ☐ does ☐ does not have an expiration date. If there is an expiration date, it is indicated below, and this verification form also expires on that date.

I hereby direct that all emergency medical services personnel comply with the Massachusetts Department of Public Health, Office of Emergency Medical Services' COMFORT CARE / Do Not Resuscitate Order Verification Protocol with regard to the above named patient.

Signature of Physician / NP / PA _____

Print Name of Physician / NP / PA	Effective Date of CC / DNR Order Verification	Expiration Date (if any) of DNR Order and CC/DNR Order Verification

Address of Physician / NP / PA

Telephone Number of Physician / NP / PA