





# Illinois Department of Public Health UNIFORM DO-NOT-RESUSCITATE (DNR) ORDER FORM

Patient's name \_\_\_\_\_

**Summarize medical condition:**

### When This Form Should Be Reviewed

This DNR order, in effect until revoked, should be reviewed periodically, particularly if –

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

### How to Complete the Form Review

1. Review the other side of this form.
2. Complete the following section.  
If this form is to be voided, write "VOID" in large letters on the other side of the form.  
After voiding the form, a new form may be completed.

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; <b>no</b> new form completed

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; <b>no</b> new form completed

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; <b>no</b> new form completed

### Advance Directives

I also have the following advance directives:

<input type="checkbox"/> Health Care Power of Attorney	_____
<input type="checkbox"/> Living Will	_____
<input type="checkbox"/> Mental Health Treatment Preference Declaration	_____

**Contact person** (name and phone number)

◆ Send this form or a copy of both sides with the individual upon transfer or discharge. ◆