uchealth

Patient's or Authorized Agent's Directive to Withhold Cardiopulmonary Resuscitation (CPR)

This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2.

Patient's information

Patient's name (printed) _____

If applicable, name of Agent/Legally authorized guardian/Parent of minor child (printed) _____

Date of birth _____ Gender: ☐ Male ☐ Female Eye color_____ Hair color_____

Race/Ethnicity: ☐ Asian or Pacific Islander ☐ Black, non-Hispanic ☐ White, non-Hispanic
☐ American Indian or Alaskan native ☐ Hispanic ☐ Other

If applicable, name of hospice program/provider _____

Physician's information

Physician's name _____

Address_____

Phone _____ Colorado license # _____

Directive Attestation

Check only the information that applies:

- ☐ **Patient.** I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.
- ☐ **Authorized agent/Legally authorized guardian/Parent of minor child.** I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient name above in the issuance of this directive. I have been advised that as a result of this directive, if the patient's heart or breathing stops or malfunctions, the patient will not receive CPR and may die.
- ☐ **Tissue donation.** I hereby make an anatomical gift, to be effective upon my death of:
  - ☐ Any needed tissues.
  - ☐ The following tissues: ☐ Skin ☐ Cornea ☐ Bone, related tissues and tendons

I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient's care and comfort. If I/the patient am/is admitted to a health care facility, this directive shall be implemented as a physician's order, pending further physician's orders.

☐ Patient signature ☐ Authorized agent/Legally authorized guardian/Parent of minor child signature	Physician signature
Date/Time	Date/Time