



MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

CCFORM 9/2006

COMFORT CARE / DO NOT RESUSCITATE
("DNR") ORDER VERIFICATION

PATIENT'S LAST NAME			PATIENT'S MIDDLE NAME OR INITIAL
PATIENT'S FIRST NAME			
DATE OF BIRTH (MM/DD/YYYY)		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	

STREET OR RESIDENTIAL ADDRESS		
CITY	STATE	ZIP CODE (5 or 9 digits)

LAST NAME OF GUARDIAN OR HEALTH CARE AGENT (If applicable)		MIDDLE NAME OR INITIAL
FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT		

PATIENT/GUARDIAN/HEALTH CARE AGENT STATEMENT (SIGNATURE AND DATE REQUIRED)	
I _____ (<input type="checkbox"/> patient <input type="checkbox"/> guardian <input type="checkbox"/> 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 <input type="checkbox"/> does <input type="checkbox"/> 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		