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		PATIEN	PATIENT'S MIDDLE NAME OR INITIAL  PATIENT'S LAST NAME			
DATE OF BIRTH (MM/DD/YYYY)	GENDER					
STREET OR RESIDENTIAL ADDRESS						
CITY			STATE	ZIP CODE (5 or 9	9 digits)	
LAST NAME OF GUARDIAN OR HEALTH	CARE AGENT (If applicable)					
FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT			MIDDLE NAME OR INITIAL			
		LPATIE	NT'S LAST NAM	E		
PATIENT/GUARDIAN/HHEALTH CARE	AGENT STATEMENT (SIGNATURE AND	DATE REQUIRED	<b>)</b> )			
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verify that the above named patient has a form, the DNR order, if current and valid, w						
Order Verification Protocol will be followed				or resource.		
Signature of Patient/Guardian/Health Care	Agent		Date	9		
Signature of Patient/Guardian/Health Care PHYSICIAN / NURSE PRACTICIONER (N ALWAYS REQUIRED)		FICATION (PHYSIC			DATES	
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