OKLAHOMA DEPARTMENT OF CORRECTIONS  
Do Not Resuscitate Consent Form

I, __________________________________________, ODOC #______________________, request limited health care as described in this document. If my heart stops beating, or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider, including but not limited to emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

Notification of Activation for a Living Will/Advance Directive and/or DNR (DOC 140138B) will never be honored in situations of self-harm or assault.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;

3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification to a physician or other health care provider of the health care agency or by oral notification to my attending physician; or

4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

_________________________________________________________________________________ ___________________________  
Signature of Patient  Date

OR

_________________________________________________________________________________ ___________________________  
Signature of Health Care Proxy-Acting under the Oklahoma Advance Directive Act and the Oklahoma Do-Not Resuscitate Act  Date

This DNR form was signed in my presence.

__________________________________________________________________________  
Signature of Witness  Date

Address: ________________________________________________________________

__________________________________________________________________________  
Signature of Witness  Date

Address: ________________________________________________________________

DOC 140138C (R 12/21)