Part 7—Instructions to Emergency Medical Services (ambulance crews) about what to do if your heart or breathing stops.

This section is optional. If you do not want the ambulance crews to revive you if your heart or breathing stops, you and your physician (or nurse practitioner or physician assistant) must both complete and sign this part.

Instructions for Part 7:

- If I stop breathing or my heart stops, I do not want the Emergency Medical Services (ambulance crews) to try to revive me. My physician, physician assistant or nurse practitioner and I have discussed this and signed the special form on the next page. I understand that this decision will not prevent me from receiving other emergency care, or comfort care from health care workers before I die.

- I understand that the form goes into effect when I have signed it **AND** it is signed by my physician, physician assistant, or nurse practitioner.

- I understand that this directive will not be followed unless my family, caretaker or I give the signed form on the next page to Emergency Medical Services (ambulance crews), and that it is solely my responsibility to make sure they see it.

- I understand that I should carry the signed form with me unless I wear health alert jewelry, such as MedicAlert, that also tells people that I do not want to be revived if my breathing or heart beat stops [Please call Maine Emergency Medical Services at 207-626-3860 to get the names of other Maine EMS approved health alert jewelry companies].

- I understand that I may revoke this directive at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry. I can also tell the ambulance crews that I have changed my mind.

- I understand that should I change my mind, it is my responsibility to tell my physician, nurse practitioner, or physician assistant and other people who have copies of the signed form.

- If I want my agent to make this decision later, my agent should take the form available at: http://www.maine.gov/dps/ems to my physician, nurse practitioner, or physician assistant when it is time to make the decision.

If you complete and sign this section, put the original in a safe place and be sure to give copies to ambulance crews, your family, your caregivers, and your physician.

DO-NOT-RESUSCITATE DIRECTIVE

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your physician (or nurse practitioner or physician assistant) must both complete and sign this part.

FOR PATIENT TO COMPLETE:

In the event that my heart or breathing stops and I am unable to speak for myself, I, _________________ [printed name] direct that no efforts be taken to restart my heart or breathing and that Emergency Medical Services (ambulance crews) if notified, will honor my directive. I have come to this decision after considering my condition and prognosis and the potential risks, burdens and benefits of refusing efforts to restart my heart or breathing.

I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my physician (or nurse practitioner or physician's assistant) and other caregivers if I change my mind.

I understand that if any health care provider has any doubts about what I want, they will try to restart my heart or breathing.

I understand that this form is not valid until both my physician, physician assistant or nurse practitioner **and** I have signed it.

❒ No expiration date **OR** ❒ Expires on _________________________

________________________________ ___________________________
Patient's Signature Date Signed

FOR PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER TO COMPLETE:

By my signature I affirm that:

(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made an expressed informed decision about resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.

__________________________ ____
Date Signed Signature and license level (MD, DO, PA or NP)

____
Printed Name

____
Telephone Number

THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES