BRITISH COLUMBIA | Ministry of Health
The Best Place on Earth

BRITISH COLUMBIA MEDICAL ASSOCIATION

NO CARDIOPULMONARY RESUSCITATION

Patients who know they have a terminal illness or who are considered at the natural end of their lives can request beforehand that no active resuscitation be started on their behalf if they are dying. This should be done after discussions with their doctor. "No active resuscitation" is defined as no cardiopulmonary resuscitation (no CPR) in the event of a respiratory and/or cardiac arrest.

This form is provided to you and/or your next of kin by your doctor to allow you to clearly state that you do not want active resuscitation to be given to you in circumstances where you can no longer make the decision for yourself. It instructs people such as ambulance attendants and emergency room personnel not to start active resuscitation on your behalf whether you are at home, in the community or in a long term care facility. The personal information collected on this form assists the health professionals noted above to carry out your wishes. If you have any questions about the collection of this information contact the **Ministry of Health at 250-952-1742 or toll-free at 1-800-465-4911.**

It is recommended that your doctor or alternate be called first to attend to your needs and not the BC Ambulance Service. You or your next of kin should have the form available to show to emergency help if they are called to come to your aid. It is desirable that you wear a no CPR bracelet to enable quick verification that you have a No CPR order in place.

If you change your wishes about this matter, then please inform your doctor and community nurse and tear up the form.

PATIENT IDENTIFICATION

SURNAME	BIRTHDATE (YY/MM/DD)
GIVEN NAMES	
ADDRESS	TELEPHONE NUMBER

SIGNED BY THE PATIENT

I, ______________________ *(patient's name in full)* understand and accept that I have been diagnosed as having a terminal illness or am considered to be at the natural end of my life and that my care is to include support and comfort only and that no active resuscitation is to be undertaken. I hereby make the consent decision that in the event of a respiratory and/or cardiac arrest, no cardiopulmonary resuscitation is to be undertaken. This decision shall be in effect unless rescinded and should be reviewed in one year.

PATIENT'S SIGNATURE	DATE

SIGNED BY THE PATIENT'S AUTHORIZED SUBSTITUTE DECISION MAKER (ASDM)

(WHERE THE PATIENT IS INCAPABLE OF MAKING A CONSENT DECISION)

I, ______________________ , am the authorized substitute decision maker
(name of the patient's authorized substitute decision maker)

of ______________________ *(name of patient identified above)* and I understand and accept that care is to include support and comfort only and that no active resuscitation is to be undertaken. I hereby make the consent decision that in the event of a respiratory and/or cardiac arrest, no cardiopulmonary resuscitation is to be undertaken. This decision shall be in effect unless rescinded and should be reviewed in one year.

SIGNATURE OF THE PATIENT'S AUTHORIZED SUBSTITUTE DECISION MAKER	DATE	SIGNATURE OF WITNESS
RELATIONSHIP OF THE PATIENT'S AUTHORIZED SUBSTITUTE DECISION MAKER TO THE PATIENT *(e.g. representative, committee of person, or temporary substitute decision maker)*		WITNESS (IN PRINT)

PHYSICIAN ONLY

PHYSICIAN'S NO CPR ORDER

- ☐ Patient (or ASDM) agrees and has signed this form
- ☐ Patient (or ASDM) agrees but has declined signing this form
- ☐ Patient (or ASDM) disagrees with my order and has declined signing this form

The above identified patient has been diagnosed as having a terminal illness, or is considered to be near the natural end of their life. I have discussed the prognosis of this illness, the life expectancy, the person's wishes and the treatment options with the patient/patient's authorized substitute decision maker. Based on this discussion, I order that in the event of a respiratory and/or cardiac arrest no cardiopulmonary resuscitation is to be undertaken. This order shall be in effect unless rescinded and should be reviewed in one year.

ATTENDING PHYSICIAN'S NAME (IN PRINT)		ALTERNATE PHYSICIAN'S NAME (IN PRINT)
ATTENDING PHYSICIAN'S ADDRESS	PHONE NUMBER	ALTERNATE PHYSICIAN'S PHONE NUMBER
ATTENDING PHYSICIAN'S SIGNATURE		DATE

WHITE COPY – TO PATIENT **YELLOW COPY** – TO ATTENDING PHYSICIAN **PINK COPY** – COMMUNITY HOME CARE NURSING SERVICES *(IF PATIENT IN CARE)*

HLTH 302.1 Rev. 2007/03/05
Developed in conjunction with the BCMA

Form may be ordered by sending a fax to: Product Distribution Services Customer Service, Fax 250-952-4442

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