

Continuation Sheet for Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) Order

(With Continuing Effect)

(For Minor)

(Made under the Advance Decision on Life-sustaining Treatment Ordinance)

(Note: Once used and attached to the DNACPR Order, this continuation sheet forms part of the Order.)

Details of DNACPR Order

This is a continuation sheet for the DNACPR Order made for (Name):
_____ (*subject person*). The effective period of the Order began on

_____/_____/_____.
(Day) (Month) (Year)

st/nd/rd/th* Extension of Effective Period

(Note: An extension should not exceed 1 year.
The extended effective period is to end before
the 18th birthday of the subject person.)

Having reviewed the current circumstances of the subject person and considered all other relevant factors, I FURTHER EXTEND the effective period of the Order. The extended effective period is to end at 24:00 hours on _____/_____/_____.
(Day) (Month) (Year)

I make the No Interest Declaration^(See Part 8 of the Order).

Signature: _____ Date of Signing: _____/_____/_____
(Day) (Month) (Year)

Name of Registered Medical Practitioner: _____

Medical Council Registration No.: _____

Hospital/Clinic*: _____ Contact Tel. No.: _____

(* Delete as appropriate.)

st/nd/rd/th* **Extension of Effective Period**

(Note: An extension should not exceed 1 year. The extended effective period is to end before the 18th birthday of the subject person.)

Having reviewed the current circumstances of the subject person and considered all other relevant factors, I FURTHER EXTEND the effective period of the Order. The extended effective period is to end at 24:00 hours on ____/____/____.
(Day) (Month) (Year)

I make the No Interest Declaration^(See Part 8 of the Order).

Signature: _____ Date of Signing: ____/____/____
(Day) (Month) (Year)

Name of Registered Medical Practitioner: _____

Medical Council Registration No.: _____

Hospital/Clinic*: _____ Contact Tel. No.: _____

(* Delete as appropriate.)

st/nd/rd/th* **Extension of Effective Period**

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(Day) (Month) (Year)

I make the No Interest Declaration^(See Part 8 of the Order).

Signature: _____ Date of Signing: ____/____/____
(Day) (Month) (Year)

Name of Registered Medical Practitioner: _____

Medical Council Registration No.: _____

Hospital/Clinic*: _____ Contact Tel. No.: _____

(* Delete as appropriate.)

st/nd/rd/th* **Extension of Effective Period**

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(Day) (Month) (Year)

I make the No Interest Declaration^(See Part 8 of the Order).

Signature: _____ Date of Signing: ____/____/____
(Day) (Month) (Year)

Name of Registered Medical Practitioner: _____

Medical Council Registration No.: _____

Hospital/Clinic*: _____ Contact Tel. No.: _____

(* Delete as appropriate.)