EMS Comfort Care Order/Patient I.D. No.
1024

Government of the District of Columbia
Department of Health
Emergency Health and Medical Services Administration

EMS Comfort Care Order

FORM MUST BE FULLY COMPLETED TO BE VALID

A. Patient Information

Name (Print legibly): _____
Last First M.I.

Patient's DOB: ____/____/____ Gender: Male: _____ Female: _____
Month Date Year

Signature of *(Check one)* ☐ **Patient** ☐ **Authorized Decision-Maker** ☐ **Surrogate**
I consent to this Order.

Name: _____ Signature: _____

SSN: _____

B. Physician's Certification and Order

- I certify that this patient has the following specified medical or terminal condition:
  _____
- If the patient's heart or breathing stops as a result of the above medical or terminal condition, I direct that the Patient receive all necessary comfort care as listed on the back of this form. Cardiopulmonary resuscitation (CPR) and advanced life support are inappropriate measures for this patient and are not to be used.
- I have explained to the patient or authorized decision-maker or surrogate, if applicable, the effect of this Comfort Care Order as explained on the back of this form, the medical alternatives to it, and the other forms of health care advance directives.
- I have also explained how this Order may be revoked, as described on the back of this form.

_____ ____/____/____
Signature of Attending Physician Date

_____ _____ (____)_____
Physician's Name (printed) Physician's License Number Physician's Phone Number

C. EMS provider check all that are applicable

_____Patient Transported _____CCO Implemented ____CCO Revoked

This form is an EMS Comfort Care Order authorized by D.C. Law 13-224. and is printed on security paper.
Photocopies are not Valid

Form Copies:

WHITE
Patient's Copy

YELLOW
Patient's medical record

BLUE
Physicians mail to:
DC DOH/EHMSA/DNR
64 New York Ave NE Suite 5000
Washington, DC 20001
or fax to: 202-671-0846

MANILLA
For ordering metal bracelet

Physician signing EMS Comfort Care Order must sign ALL IDENTIFICATION INSERTS

EHMSA-DNR-0000 1/04

ORTANT: Type or print information clearly, detach identification insert, fold strip
ien insert into plastic bracelet. **Physician** must the affix bracelet to patient.

District of Columbia
EMS Comfort Care Order
CCO/Patient I.D. # 1024
Patient Name: _____
MD Name: _____
MD Phone: _____

MPORTANT: Type or print information clearly, detach identification insert, fold strip
insert into plastic bracelet. **Physician** must the affix bracelet to patient.

District of Columbia
EMS Comfort Care Order
CCO/Patient I.D. # 1024
Patient Name: _____
MD Name: _____
MD Phone: _____

ORTANT: Type or print information clearly, detach identification insert, fold strip
insert into plastic bracelet. **Physician** must the affix bracelet to patient.

District of Columbia
EMS Comfort Care Order
CCO/Patient I.D. # 1024
Patient Name: _____
MD Name: _____
MD Phone: _____