SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

Use of original form is strongly encouraged. Photocopies and facsimiles of completed POLST forms are legal and valid.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Other Contact Information (Optional)			
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

Completing POLST

- POLST should be completed only for patients with advanced frailness or advanced life-limiting illness.
- Must be completed by a health care professional based on medical indications, a discussion of treatment benefits and burdens, and elicitation of patient preferences.
- POLST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- POLST must be signed by patient/resident or healthcare surrogate/proxy to be valid.

Using POLST

- Any section of POLST not completed implies full treatment for that section.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only," should be transferred to a setting able to provide comfort, such as a hospice unit.
- A person who chooses either "comfort measures only" or "limited additional interventions" should not be entered into a Level I trauma system.
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- A person with capacity or the surrogate/proxy (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.

Reviewing POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

(1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person's health status, or

(3) The person's treatment preferences change.

To void this form, draw line through sections A through E and write "VOID" in large letters.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	Middle Int.

Date of Birth: (mm/dd/yyyy)	Gender	Last 4 SSN:
___ ___ ___	☐ M ☐ F	☐☐☐☐

Address: (street/ city/ state/ zip)

A — CARDIOPULMONARY RESUSCITATION(CPR): Patient has no pulse and/or is not breathing

Check One

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders in B and C.

B — MEDICAL INTERVENTIONS: If patient has pulse and is breathing.

Check One

☐ **Comfort Measures Only (Allow Natural Death)** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Consider hospice referral if appropriate.**
Treatment Plan: Maximize comfort through symptom management.

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer to hospital if indicated. Generally avoid the intensive care unit.**
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer to hospital and /or intensive care unit if indicated.**
Treatment Plan: Full treatment including life support measures in the intensive care unit.

Additional Orders:_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible.

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders:_____

D — HOSPICE or PALLIATIVE CARE (complete if applicable) - consider referral as appropriate

Check One

☐ Patient/Resident Currently enrolled in Hospice Care	☐ Patient/Resident Currently enrolled in Palliative Care	Hospice/Palliative Care Team/Contact Name & Phone Number

E — DOCUMENTATION OF DISCUSSION:

Check One

☐ Patient (Patient has capacity) ☐ Health Care Representative or legally recognized surrogate

☐ Parent of minor ☐ Court-Appointed Guardian ☐ Other

SIGNATURES

Print Physician Name	MD/DO License #	Phone Number

Physician Signature **(mandatory)**	Date

Print Patient/Resident or Surrogate/Proxy Name	Relationship (write 'self' if patient)

Patient or Surrogate Signature **(mandatory)**	Date