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

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name /First/Middle Initial

Date of Birth ____ ____ ____ **Last 4 #SSN** ___ ___ ___ ___ **Gender** ☐ M ☐ F

A Check One — Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

☐ CPR/Attempt Resuscitation ☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

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

B Check One — Medical Interventions: Person has pulse and/or is breathing.

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer:** *EMS contact medical control to determine if transport indicated to provide adequate comfort.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

Additional Orders: (e.g. dialysis, etc.) _____

_____

C Check One — Antibiotics:

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal.
☐ Use antibiotics if life can be prolonged.

Additional Orders: _____

_____

D Check One — Artificially Administered Nutrition:

Always offer food and liquids by mouth if feasible.

☐ No artificial nutrition by tube.
☐ Trial period of artificial nutrition by tube.
(Goal: _____
_____)
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

_____

E Medical Condition/Goals:

F Signatures: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information:

Discussed with:
☐ Patient ☐ Parent of Minor
☐ Legal Guardian
☐ Health Care Agent (DPOAHC)
☐ Spouse/Other:
_____

PRINT — Physician/ARNP/PA-C Name	Phone Number
Physician/ARNP/PA-C Signature ***(mandatory)***	Date
Patient or Legal Surrogate Signature ***(mandatory)***	Date

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid

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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

Person has: ☐ Health Care Directive (living will) ☐ DPOAHC ☐ Living Will Registry **Encourage all advance care planning documents to accompany POLST**

Directions for Health Care Professionals

Completing POLST

- Must be completed by health care professional.
- Should reflect person's current preferences and medical indications. Encourage completion of an advance directive.
- POLST must be signed by a physician/NP/PA to be valid. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

SECTION A:
- No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation."

SECTION B:
- 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 (e.g., treatment of a hip fracture).
- 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 Additional Interventions" or "Full Treatment."

SECTION D:
- Oral fluids and nutrition must always be offered if medically feasible.
- A person with capacity or the surrogate of a person without capacity, can void the form and request alternative treatment.

Reviewing POLST

This POLST should be reviewed periodically whenever:

(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 "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

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

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED