

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 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

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

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

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

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

Check One **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.**

LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **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 ANTIBIOTICS

Check One 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 ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquids by mouth if feasible.

Check One No artificial nutrition by tube.

Trial period of artificial nutrition by tube. (Goal: _____)

Long-term artificial nutrition by tube.

Additional Orders: _____

E SUMMARY OF GOALS

<p>Discussed with:</p> <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Durable Power of Attorney for Health Care <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other: _____	<p>The basis for these orders is: (check all that apply)</p> <input type="checkbox"/> Patient's request <input type="checkbox"/> Patient's known preference <input type="checkbox"/> Patient's best interest <input type="checkbox"/> Medical futility	
Print Physician/ARNP/PA-C Name	Physician/ARNP/PA-C Signature (mandatory)	Phone Number
Patient/Resident or Legal Surrogate for Health Care 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

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

Completing POLST

- Must be completed by a health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician, nurse practitioner or PA-C to be valid. Verbal orders are acceptable with follow-up signature by physician or nurse practitioner in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any section of POLST not completed implies full treatment for that section.
- 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 (e.g., pinning of a hip fracture).
- 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 (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 "Physician Orders" and write "VOID" in large letters.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised November 2004