

PowerForm Signer Information

Please enter your name and email to begin the signing process.

Your Role:

Patient/Advocate *

Your Name:

Your Email:

Please provide information for any other signers needed for this document.

Role:

Physician

Name:

Email:

[Begin Signing](#)

If there are other 'roles' required for this document to be completed, please enter the name and email of these other recipients. An email will be sent inviting them to sign along with you.

PRINT PERSON'S NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

PRINT PERSON'S ADDRESS

CONTACT INFORMATION

PRINT SURROGATE HEALTH CARE DECISION MAKER

ADDRESS

PHONE NUMBER

DIRECTIONS FOR HEALTH CARE PROFESSIONAL**COMPLETING POLST**

- Must be completed by a physician or advance practice nurse.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

MODIFYING AND VOIDING POLST - *An individual with decision making capacity can always modify/void a POLST at any time.*

- A surrogate, if designated in Section E on the front of this form, may, at any time, void the POLST form, change his/her mind about the treatment preferences or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision maker may request to modify the orders based on the known desires of the person or, if unknown, the person's best interest.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

SECTION A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis in order for the person to set realistic goals.

SECTION B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

SECTION C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

SECTION D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management.

SECTION E

This section is applicable in situations where the person has decision making capacity when the POLST form is completed. A surrogate may **ONLY** void or modify an existing POLST form, or execute a new one, if named in this section by the person.

SECTION F

POLST must be signed by a practitioner, meaning a physician or APN, to be valid. Verbal orders are acceptable with follow-up signature by physician/APN in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED