

Patient

Agent

Guardian

Patient

Physician

Witness

Receive a Copy

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### PowerForm Signer Information

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

Your Role:

**Patient**

Your Name:

Your Email:

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

Role:

**Agent**

Name:

Email:

Role:

**Guardian**

Name:

Email:

Role:

**Parent**

Name:

Email:

Role:

**Physician**

Name:

Email:

Role:

**Witness**

Name:

Email:

Role:

**Receive a Copy**

Name:

Email:

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


**NEVADA POLST (Physician Order for Life-Sustaining Treatment)**  
**HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY**  
 Faxed, copied or electronic versions of a Nevada POLST are legal and valid

**SIDE 1: Medical Orders**

Consult this form when patient lacks decisional capacity. It is intended to be honored by any health-care provider who treats the patient in any health-care setting, including, without limitation, a residence, health care facility or the scene of a medical emergency (NRS 449.694.). A section not completed does not invalidate the rest and indicates full treatment for that section.	Last Name/First/Middle Initial		
	Date of Birth (dd/mm/yr)	Last 4 SSN	Gender
	/ /	_____	M F
<b>Section A</b> CPR Check one only	<b>CARDIOPULMONARY RESUSCITATION (CPR).</b> <i>Patient/resident has no pulse &amp; is not breathing.</i> <input type="checkbox"/> Attempt Resuscitation (CPR) (See Section B: Full Treatment required) <input type="checkbox"/> Allow Natural Death (Do Not Attempt Resuscitation) If available, EMS-DNR #: _____ <b>When not in cardiopulmonary arrest follow orders in Section B</b>		
<b>Section B</b> Interventions	<b>MEDICAL INTERVENTIONS.</b> <i>Patient/resident has pulse and/or is breathing.</i> Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped. <b>1. <input type="checkbox"/> Comfort Measures Only.</b> The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth as tolerated, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. Transfer only if comfort needs cannot be met in current location. <i>Other Instructions:</i> _____ <b>2. Limited Medical Interventions. Comfort measures always provided.</b> <b>a. Life-Sustaining Antibiotics.</b> <input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms <input type="checkbox"/> Administer antibiotics by mouth as necessary <input type="checkbox"/> Administer antibiotics IV as necessary <i>Other Instructions:</i> _____ <b>b. Artificially Administered Fluids and Nutrition.</b> <input type="checkbox"/> No feeding tube <input type="checkbox"/> No IV fluids <input type="checkbox"/> Defined trial period of feeding tube <input type="checkbox"/> Defined trial period of IV fluids <input type="checkbox"/> Long term feeding tube <input type="checkbox"/> Long term IV fluids <i>Other Instructions:</i> _____ <b>c. Other Limitations of Medical Interventions.</b> <input type="checkbox"/> No intensive care admission <input type="checkbox"/> No lab work <input type="checkbox"/> No x-ray <input type="checkbox"/> No antiarrhythmic drugs <input type="checkbox"/> No IV (assure agreement with <b>a.</b> & <b>b.</b> above) <input type="checkbox"/> No dialysis <input type="checkbox"/> No hyperalimentation <input type="checkbox"/> No electrolyte or acid/base corrective measures <i>Other Instructions:</i> _____ <b>3. <input type="checkbox"/> Full Treatment.</b> Includes care above plus endotracheal intubation and cardioversion. <i>Additional Instructions:</i> _____		
<b>Section C</b> Physician Signature	Date (Required)	Physician Signature (Required)	Physician Name (Print)
	Physician Office Address	Physician Phone	Physician License No.

**Send original with patient when discharged or transferred**

**NEVADA POLST (Physician Order for Life-Sustaining Treatment)**Patient Name: EXAMPLE DOB: \_\_\_\_\_**SIDE 2: Supplementary Patient Preferences**

<b>Section D</b> Organ Donation	<b>ORGAN DONATION</b> <input type="checkbox"/> I have documented on my license or state issued ID that I would like to donate my organs <i>Other Instructions:</i> _____	
<b>Section E</b> Advance Directive	<b>The following documents/persons have further information regarding patient's/resident's preferences:</b> <b>1. Advance Directive (AD): Living Will, Declaration, Durable Power of Attorney (DPOA) for Health Care</b> <input type="checkbox"/> NO <input type="checkbox"/> YES <b>If no AD, skip to #2 below</b> AD Registered with Secretary of State: <input type="checkbox"/> NO <input type="checkbox"/> YES - Registration No: _____ Other location: _____ Appointed Agent #1: _____ Telephone No: _____ Appointed Agent #2: _____ Telephone No: _____  <b>2. If no agent appointed, another person will make decisions for you as determined by Nevada law.</b> <b>3. Court-Appointed Guardian</b> <input type="checkbox"/> NO <input type="checkbox"/> YES    Name: _____ Telephone No: _____	
<b>Section F</b> Signatures	<b>Patient / Agent / Parent / Guardian (circle one) Approval</b> I have discussed this form, its treatment options and their implications for sustaining life with my / the patient's health care provider. This form reflects my treatment preferences. Signature: _____ Date: _____ <b>Consent for Sections A and B above were discussed with and given by:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Adult Child <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Agent (DPOA) <input type="checkbox"/> Other: _____ Witnessed by (for any checked above): _____ Date: _____ <b>Preparer's Information</b> Preparer's Name (print): <u>EXAMPLE</u> Date: _____ Signature of Person Preparing Form: _____	
<b>Section G</b> Registry	Physician initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Living Will Lockbox. Authorization forms can be found at: <a href="http://www.LivingWillLockbox.com">www.LivingWillLockbox.com</a> .	
<b>GENERAL INSTRUCTIONS</b> <ul style="list-style-type: none"> <li>Record all treatments entered on this POLST as orders in patient's chart.</li> <li>Copy POLST form for patient record.</li> <li>If orders change complete a new POLST and write VOID across this POLST.</li> <li>If no new form is completed, full treatment and resuscitation may be provided.</li> <li>Transfer or discharge patient with a current POLST form.</li> </ul> <b>WHEN THIS FORM SHOULD BE REVIEWED</b> This form (POLST) should be reviewed periodically and if: <ul style="list-style-type: none"> <li>The patient/resident is transferred from one care setting or level to another, or</li> <li>There is a substantial change in patient/resident health status, or</li> <li>The patient/resident treatment preferences change.</li> </ul> <b>THE LATEST VERSION OF THE POLST FORM IS AVAILABLE FROM THE NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH.</b>		For Internal Use
<b>Send original with patient when transferred or discharged</b>		