

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

Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial

Date of Birth Last 4 #SSN Gender
 _____ _____ M F

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST form is always voluntary. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A **CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.
 Check One CPR/Attempt Resuscitation DNAR/Do Not Attempt Resuscitation (Allow Natural Death)
Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

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 hospital 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 **SIGNATURES:** The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Guardian with Health Care Authority <input type="checkbox"/> Spouse/Other as authorized by RCW 7.70.065 <input type="checkbox"/> Health Care Agent (DPOAHC)	PRINT — Physician/ARNP/PA-C Name EXAMPLE	Phone Number
	<input checked="" type="checkbox"/> Physician/ARNP/PA-C Signature (mandatory)	Date (mandatory)
PRINT — Patient or Legal Surrogate Name		Phone Number
<input checked="" type="checkbox"/> Patient or Legal Surrogate Signature (mandatory)		Date (mandatory)
Person has: <input type="checkbox"/> Health Care Directive (living will) <input type="checkbox"/> Durable Power of Attorney for Health Care		Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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

D NON-EMERGENCY MEDICAL TREATMENT PREFERENCES**ANTIBIOTICS:**

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

MEDICALLY ASSISTED NUTRITION:

Always offer food and liquids by mouth if feasible.

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

ADDITIONAL ORDERS: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

X Physician/ARNP/PA-C Signature

Date

X Patient or Legal Surrogate Signature

Date

DIRECTIONS FOR HEALTH CARE PROFESSIONALS**Completing POLST**

- The POLST is usually for persons with serious illness or frailty.
- Completing a POLST form is always voluntary.
- The POLST must be completed by a health care provider based on the patient's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

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

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTION A:

- No defibrillator 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.

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.

A competent adult, or the surrogate of a person who is not competent, can void the form and request alternative treatment.

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
			<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

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Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

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